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Comprehensive Care for Joint Replacement Payment Model
Proposed Rule Fact Sheet

Submission of Comments

This document provides an overview of the proposed rule to implement a new Comprehensive Care for Joint Replacement (CCJR) payment model for Medicare Part A and B. The proposed rule with comment period is available in the July 14, 2015, *Federal Register*.

Comments on the proposed rule are due by Sept. 8, 2015.

Because of staff and resource limitations, CMS cannot accept comments by fax.

You may, and CMS encourages you to, submit electronic comments on the regulation to http://www.regulations.gov. Follow the instructions under the "submit a comment" tab.

Written comments may be sent regular mail to the following address:

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–5516–P
P.O. Box 8013
Baltimore, MD 21244-1850

Written comments can also be sent via express/overnight mail to the following address:

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–5516–P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Overview

CMS released a proposed rule that would implement a new Medicare Part A and B payment model under section 1115A of the Social Security Act (The Act), called the Comprehensive Care for Joint Replacement (CCJR) model, in which acute care hospitals in certain selected geographic areas would receive retrospective bundled payments for episodes of care for lower extremity joint replacement (LEJR) or reattachment of a lower extremity. The intent of the model is to promote quality and financial accountability for episodes of care surrounding these procedures. Under the proposal, all related care within 90 days after the date of hospital discharge from the joint replacement procedure would be included in the episode of care. CMS believes this five-year model will further its goals in improving the efficiency and quality of care for Medicare beneficiaries for these common medical procedures. CCJR will test whether bundled payments to acute care hospitals for LEJR episodes of care will reduce Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries. During the five performance years, CMS would continue paying hospitals and other providers according to the usual Medicare fee-for-service (FFS) payment systems. However, after the completion of a performance year, the Medicare claims payments for furnished beneficiary services during the episode, based on claims data, would be combined to calculate an actual episode payment.

Background

Under the CCJR model, acute care hospitals in certain selected geographic areas will receive bundled payments for episodes of care where the diagnosis at discharge includes an LEJR or reattachment of a lower extremity that was furnished by the hospital. CMS is proposing that the bundled payment will be paid retrospectively through a reconciliation process. Hospitals and other providers and suppliers will continue to submit claims and receive payment via the usual Medicare FFS payment systems. All related care covered under Medicare Part A and Part B within 90 days after the date of hospital discharge from the joint replacement procedure will be included in the episode of care.

CMS has previously used its statutory authority under section 1115A of the Act to test bundled payment models, such as the Bundled Payments for Care Improvement (BPCI) initiative. Bundled payments for multiple services in an episode of care hold participating organizations financially accountable for an episode of care. The BPCI initiative is voluntary in nature, and under that model, CMS pays a bundled payment for an episode of care only to entities that have elected to participate in the model. Interested participants must apply in order to participate in the model. The CCJR model is different from BPCI because it would **require** participation of all hospitals (with limited exceptions) throughout selected geographic areas, which would result in a model that includes varying hospital types. However, the BPCI's design informs and supports the proposed CCJR model.

To date, CMS has not tested an episode payment model with bundled payments in which providers are required to participate. As such, it is interested in testing and evaluating the impact of a bundled payment approach for LEJR procedures in a variety of circumstances, especially among those hospitals that may not otherwise participate in such a test. This proposed model

would allow CMS to gain experience with making bundled payments to hospitals with diverse characteristics. It would also stimulate the rapid development of new evidence-based knowledge, allow CMS to learn more about the patterns of inefficient utilization of healthcare services, and offer the agency insight on how to incentivize the improvement of quality for common LEJR procedure episodes.

Excluded Hospitals

Maryland hospitals are among those that would be excluded from the program because they are paid under rates set by the state, instead of the inpatient prospective payment system (IPPS) or outpatient prospective payment system (OPPS). Critical access hospitals (CAHs) would also be excluded from the model. CMS also proposes to exclude certain IPPS hospitals participating in the BCPI program. Specifically, it would exclude (during the time that their qualifying episodes are included in one of the BPCI models) Model 1 BPCI participant hospitals that are active as of July 1, 2015, as well as episode initiators for LEJR episodes in the risk-bearing phase of Model 2 or 4 of BPCI, as of July 1, 2015. If the participant hospital is not an episode initiator for LEJR episodes under BPCI Model 2, then LEJR episodes initiated by other providers or suppliers under BPCI Model 2 or 3 (where the surgery takes place at the participant hospital) would be excluded from CCJR.

Episode Initiators

In the BPCI Model 2, LEJR episode initiators are either acute care hospitals where the LEJR procedure is performed, or physician group practices whose physician members are the admitting or operating physician for the hospital stay. However, under the BPCI, it is possible that only some Medicare cases that could potentially be included in an LEJR episode at a specific hospital are actually being tested in BPCI. Under the proposed CCJR model, episodes would begin with admission to an acute care hospital for an LEJR procedure that is paid under the IPPS through Medical Severity Diagnosis-Related Group (MS–DRG) 469 (major joint replacement or reattachment of lower extremity with major complications or comorbidities (MCC)) or MS-DRG 470 (major joint replacement or reattachment of lower extremity without MCC), and end 90 days after the date of discharge from the hospital, considering the course of recovery from LEJRs for Medicare beneficiaries. For the CCRJ model, CMS proposes that acute care IPPS hospitals would be the only episode initiators. Also, unlike BPCI the CCJR proposed rule does not include a role for convening organizations.

Clinical Dimension of Episodes of Care

As mentioned above, an episode of care in the CCJR model begins with an admission to an acute care hospital (the anchor hospitalization) paid under MS–DRG 469 or MS-DRG 470 under the IPPS during the model performance period, and ends 90 days after discharge from the acute care hospital in which the anchor hospitalization took place. This proposal to begin the episode upon admission for the anchor hospitalization is consistent with LEJR episode initiation under Model 2 of BPCI. While CMS is not proposing to begin the episode prior to the inpatient hospital admission, its proposed episode definition includes all services that are already included in the IPPS payment based on established Medicare policies. These services would include diagnostic services related to the admission that are provided by the admitting hospital or by an entity

wholly owned or operated by the admitting hospital within three days prior to and including the date of admission.

Options for Geographic Area Selection
CMS proposes to choose 75 (out of the 196 eligible) MSAs from its proposed eight selection groups. The number of MSAs to be chosen in the eight selection groups is shown in Table 2 of the proposed rule. ***Appendix 1*** includes a list of the MSAS that would be included in the CCJR model (Table 3 of the proposed rule). CMS decided that a methodology that proportionally under-weighted more efficient MSAs and over-weighted more expensive MSAs was the most appropriate approach to fulfilling the goal to increase efficiencies and savings for LEJR cases, while maintaining or improving the overall quality of care.

Although MSAs are revised periodically, with additional counties added or removed, CMS proposes to maintain the same cohort of selected hospitals throughout the model's five-year performance period, as this approach is believed to best maintain the consistency of the participants in the model, which is crucial for its ability to evaluate results. Thus, CMS would not add hospitals or remove them from the model if new counties are added or removed from the MSAs after the program has started. Although a hospital could not be added to or removed from the model after the program begins, the possibility of adding a hospital that is opened or incorporated within a selected MSA during the period of performance would be retained.

Covered Beneficiaries
The defined population of Medicare beneficiaries whose care will be included in CCJR meet the following criteria upon admission to the anchor hospitalization:

- The beneficiary is enrolled in Medicare Part A and Part B throughout the duration of the episode
- The beneficiary's eligibility for Medicare is not on the basis of end stage renal disease
- The beneficiary is not enrolled in any managed care plan (for example, Medicare Advantage, Health Care Prepayment Plans, or cost-based health maintenance organizations);
- The beneficiary is not covered under a United Mine Workers of America health plan, which provides healthcare benefits for retired mine workers
- Medicare is the primary payer

Because of Medicare's payment methodology, CMS is unable to capture or appropriately attribute the related Medicare payments to the episodes of those beneficiaries whose care would be excluded from the model.

Included Services
All CCJR episodes, beginning with the admission for the anchor hospitalization under MS–DRG 469 or MS-DRG 470, through the end of the 90-day episode, include all items and services paid under Medicare Part A or Part B, with the exception of those that are unrelated to the episode. CMS proposes that disease-related diagnoses, such as osteoarthritis of the hip or knee, be included. It also proposes that body system-related diagnoses be included because they relate to

complications that may arise from interactions with the health care system. The items and services ultimately included in the episode after the exclusions are applied are called related items and services. Related items and services included in CCJR episodes would include the following:

- Physicians' services
- Inpatient hospital services (including readmissions)
- Inpatient psychiatric facility services
- Long-term care hospital services
- Inpatient rehabilitation facility (IRF) services
- Skilled nursing facility (SNF) services
- Home health agency (HHA) services
- Hospital outpatient services
- Independent outpatient therapy services
- Clinical laboratory services
- Durable medical equipment
- Part B drugs
- Hospice

Excluded Services

CMS proposes to exclude only those Medicare items and services furnished during the episode that are unrelated to LEJR procedures based on clinical justification. Exclusions from CCJR episodes are based on care for unrelated clinical conditions represented by MS–DRGs for readmissions during the episode and ICD–9 CM codes for Part B services furnished during the episode after discharge from the anchor hospitalization. CMS also proposes to exclude from CCJR drugs that are paid outside of the MS–DRG, including hemophilia clotting factors identified through Healthcare Common Procedure Coding System code, diagnosis code, and revenue center on IPPS claims. Further, CMS proposes to exclude IPPS new technology add-on payments for drugs, technologies, and services from CCJR episodes, as well as admissions for oncology and trauma medical MS–DRGs. The complete lists of proposed excluded MS–DRGs for readmissions, and proposed excluded ICD–9–CM codes for Part B services, are posted on the CMS website at: *http://innovation.cms.gov/initiatives/ccjr/*. Please see ***Appendices 2a through 2d*** for the lists of these excluded services.

Canceled Episodes

CMS proposes that once the episode begins for a beneficiary whose care is included in CCJR episodes, it continues until the end, unless it is canceled because the beneficiary no longer meets the same inclusion criteria proposed for the beginning of the episode. When an episode is canceled, the services furnished to beneficiaries prior to and following the cancellation will continue to be paid by Medicare, but CMS will not calculate actual episode spending that would be reconciled against the target price for the beneficiary's care under CCJR. The following circumstances would qualify for cancellation under the proposal:

- The beneficiary is readmitted to an acute care hospital during the episode and discharged under MS–DRG 469 or MS-DRG 470. (In this case, the first episode would be canceled and a new LEJR episode would begin for the beneficiary.)
- The beneficiary dies during the anchor hospitalization.
- The beneficiary initiates an LEJR episode under BPCI Models 1, 2, 3, or 4.

In the case of beneficiary death during the anchor hospitalization, CMS believes it would be appropriate to cancel the episode as there are limited efficiencies that could be expected during the anchor hospital stay itself. In the case of beneficiary readmission during the first CCJR episode for another LEJR (typically a planned staged second procedure), CMS does not believe it would be appropriate to include two episodes in the model with some time periods overlapping, as that could result in attribution of the Medicare payment for two periods of post-acute care to a single procedure.

Methodology for Setting Episode Prices and Paying Model Participants under the CCJR Model

The five performance years under the CCJR model would align with calendar years, beginning Jan. 1, 2016. The following table (Table 6 in the proposed rule) includes details on which episodes would be included in each of the five performance years.

TABLE 6—PERFORMANCE YEARS FOR CCJR MODEL

Performance year	Calendar year	Episodes included in performance year
1	2016	Episodes that start on or after January 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.

CMS would apply the CCJR episode payment methodology retrospectively. A retrospective episode payment approach is currently being utilized under BPCI Model 2. Under this proposal, all providers and suppliers caring for Medicare beneficiaries in CCJR episodes would continue to bill and be paid as usual under the applicable Medicare payment system. After the completion of a CCJR performance year, Medicare claims for services furnished to beneficiaries that year would be grouped into episodes and aggregated. Participant hospitals' CCJR episode quality and actual payment performance would be assessed and compared against episode quality thresholds and target prices. CMS would then determine if Medicare would make a reconciliation payment to the hospital (which would be phased in beginning with year two through five only), or if the hospital would have to repay money to Medicare.

To ''phase in'' this two-sided risk, during the first year of a hospital's financial responsibility for repayment (performance year two—there would be no downside responsibility in performance year one), CMS would set an episode target price that partly mitigates the amount that it would be required to repay. CMS believes that this payment approach can accomplish the objective of testing episode payment in a broad group of hospitals, including financial incentives to

streamline care delivery around that episode, without requiring core billing and payment changes by providers and suppliers, which would create substantial administrative burden.

Proposed Episode Target Price-Setting Methodology

CMS proposes to establish CCJR target prices for MS-DRG 469 and MS-DRG 470 for each participant hospital. CMS intends to calculate and communicate episode target prices to participant hospitals prior to the performance period in which they apply. The proposed approach to setting target prices incorporates the following features:

- Set different target prices for episodes anchored by MS-DRG 469 versus MS-DRG 470
- Use three years of historical Medicare payment data grouped into episodes of care according to the episode definition proposed
- Apply Medicare payment updates to historical episode data to ensure hospitals are incentivized based on historical utilization and practice patterns
- Blend together hospital-specific and regional historical CCJR episode payments, transitioning from primarily provider-specific to completely regional pricing over the course of the five performance years
- Normalize for provider-specific wage adjustment variations in Medicare payment systems when combining provider-specific and regional historical CCJR episodes
- Pool together CCJR episodes anchored by MS DRGs 469 and 470 to use a greater historical CCJR episode volume and set more stable prices
- Apply a discount factor to serve as Medicare's portion of reduced expenditures from the CCJR episode, with any remaining portion of reduced Medicare spending below the target price potentially available as reconciliation payments to the participant hospital where the anchor hospitalization occurred

Whether a participant hospital receives reconciliation payments or has to repay Medicare for the CCJR model will depend on the hospital's quality and actual payment performance relative to episode quality thresholds and target prices. For episodes in years one, three, four, and five, a participant hospital would have eight target prices, one for each of the following:

- MS-DRG 469—Anchored episodes that were initiated between Jan. 1 and Sept. 30 of the performance year;
- MS-DRG 470—Anchored episodes that were initiated between Jan. 1 and Sept. 30 of the performance year;
- MS-DRG 469—Anchored episodes that were initiated between Oct. 1 and Dec. 31 of the performance year;
- MS-DRG 470—Anchored episodes that were initiated between Oct. 1 and Dec. 31 of the performance year;
- MS-DRG 469—Anchored episodes that were initiated between Jan. 1 and Sept. 30 of the performance year;
- MS-DRG 470—Anchored episodes that were initiated between Jan. 1 and Sept. 30 of the performance year;
- MS-DRG 469—Anchored episodes that were initiated between Oct. 1 and Dec. 31 of the performance year;

- MS–DRG 470—Anchored episodes that were initiated between Oct. 1 and Dec. 31 of the performance year

For episodes beginning in performance year two, a participant hospital would have 16 target prices. These would include the same combinations as the other four performance years, but one set for determining potential reconciliation payments, and the other for determining potential Medicare repayment amounts, as part of the phasing in of two-sided risk.

Hospital-Specific and Regional Historical Data Exception

CMS proposes an exception to the blended hospital-specific and regional pricing approach for hospitals with low historical CCJR episode volume, which are those with fewer than 20 CCJR episodes in total across the three historical years used to calculate target prices. For these hospitals, CMS would calculate target prices based fully on regional episode payments in all performance years. Another exception would be for hospitals receiving a new CMS Certification Number (CCN) during the 24 months prior to, or during, the performance period for which target prices are being calculated. For participant hospitals with new CCNs that formed from a merger with or split from previously existing hospitals, CMS would calculate hospital-specific historical payments using the episodes attributed to the previously existing hospitals. For new hospitals with new CCNs, CMS would calculate target prices based fully on regional episode payments in all performance years.

Trending of Historical Data

CMS would use three years of historical CCJR episodes for calculating CCJR target prices. The three historical years used would be updated every other year.

- Performance years one and two would use historical CCJR episodes that started between Jan. 1, 2012, and Dec. 31, 2014.
- Performance years three and four would use historical episodes that started between Jan. 1, 2014, and Dec. 31, 2016.
- Performance year five would use episodes that started between Jan. 1, 2016, and Dec. 31, 2018.

CMS proposes to calculate CCJR episode target prices using a blend of hospital-specific and regional historical average CCJR episode payments, including CCJR episode payments for all CCJR-eligible hospitals in the same U.S. Census division. CMS would blend two-thirds of the hospital-specific episode payments and one-third of the regional episode payment to set a participant hospital's target price for the first two performance years of the CCJR model (CY16 and CY17). CMS notes that the effects of updating hospital-specific data on the target price could be limited as the regional contribution to the target price grows. Thus, for performance year three of the model (CY18) when the first historical episode data update would occur, CMS would adjust the proportion of the hospital-specific and regional episode payments used to calculate the episode target price to one-third hospital-specific and two-thirds regional. Finally, CMS would use only regional historical CCJR episode payments for performance years four and five of the model (CY19 and CY20) to set a participant hospital's target price, rather than a blend between the hospital-specific and regional episode payments.

Some payment variation may exist in the three years of historical CCJR episodes due to Medicare payment systems updates, and national changes in utilization patterns. CMS does not intend to have CCJR incentives be affected by Medicare payment system rate changes that are beyond hospitals' control. To mitigate the effects of these system updates and changes in national utilization practice patterns within the three years of historical CCJR episodes, CMS would inflate the two oldest years of historical episode payments to the most recent year of the three historical years. CMS would trend forward each of the two oldest years using the changes in the national average CCJR episode payments. CMS would also apply separate national trend factors for episodes anchored by MS-DRG 469 versus MS-DRG 470 to capture any MS-DRG-specific payment system updates or national utilization pattern changes.

Historical Episode Payment Updates for Ongoing Payment System Updates

CMS proposes to prospectively update historical CCJR episode payments to account for ongoing Medicare payment system (IPPS, OPPS, IRF, PPS, SNF, PFS) updates to the historical episode data, and ensure it incentivizes hospitals based on historical utilization and practice patterns, not Medicare payment system rate changes that are beyond hospitals' control. To ensure the different payment system updates that go into effect on January 1 and October 1 are accounted for, CMS proposes to update historical episode payments for Medicare payment system updates, and calculate target prices separately for episodes initiated between Jan. 1 and Sept. 30 versus Oct. 1 and Dec. 31 of each performance year.

Special Payment Provisions Under Existing Medicare Payment Systems

Many of the existing Medicare payment systems have special payment provisions to improve quality and efficiency in service delivery. Currently, IPPS hospitals are subject to incentives under programs like the Hospital Value-Based Purchasing Program (HVBP) and the Hospital-Acquired Condition Reduction Program. Since the intent of the CCJR model is to further test episode payment incentives toward improvements in quality and efficiency beyond Medicare's existing policies, CMS proposes that the Medicare repayment be independent of, and not affect, these special payment provisions. CMS would take adjustment out of the benchmark and actual performance calculations. CMS believes that failure to exclude these special payment provisions would create incentives that are not aligned with the intent of the CCJR model. CMS also proposes to account for the effects of sequestration when calculating actual episode payments, setting episode target prices, comparing actual episode payments with target prices, and determining whether a reconciliation payment should be made to the hospital or hospitals should repay Medicare.

Payment for Services That Extend Beyond the Episode

CMS believes there would be some instances where a service included in the episode begins during the episode, but concludes after the end of the episode and for which Medicare makes a single payment under an existing payment system. CMS proposes that, in such instances, these payments would be prorated so that only the portion attributable to care during the episode is attributed to the episode payment when calculating actual Medicare payment for the episode.

High-Payment Episodes

CMS wants to ensure that hospitals have some protection from the variable repayment risk for especially high-payment episodes, where the clinical scenarios for these cases each year may

differ significantly and unpredictably. In order to limit the hospital's responsibility for these payment cases, CMS would utilize a pricing adjustment for high-payment episodes that would incorporate a high-payment ceiling at two standard deviations above the mean episode payment amount in calculating the target price, and in comparing actual episode payments during the performance year to the target prices. The high-episode payment ceiling for episodes in a given performance year would be calculated based on MS-DRG anchor-specific episodes in each region. To achieve stability and consistency in the pricing methodology, this policy would be adopted for all years of the model, regardless of the reconciliation payment opportunity or repayment obligation in a given performance year.

Wage Adjustment Variations

Some variation in historical CCJR episode payments across hospitals in a region may be due to wage adjustment differences in Medicare's payments. To preserve how wage levels affect provider payment amounts, while minimizing the distortions introduced when calculating the regional component, CMS proposes that the IPPS wage index applicable to the anchor hospitalization for each historical episode be used to normalize for provider-specific wage index variations in historical episode payments across hospitals when calculating blended target prices. To accomplish this normalization, CMS would divide a hospital's historical episode payments by the wage normalization factor. CMS would reintroduce the hospital-specific wage variations by multiplying episode payments by the wage normalization factor when calculating the target prices for each participant hospital. When reintroducing the hospital-specific wage variations, the IPPS wage index would be the one that applies to the hospital during the period for which target prices are being calculated (for example, the FY16 wage index would apply for the target price calculations for episodes that begin between Jan. 1 and Sept. 30, 2016).

Combination of CCJR Episodes

CMS proposes to pool together CCJR episodes anchored by MS-DRG 469 and MS-DRG 470 for target price calculations to use a greater historical CCJR episode volume, and set more stable target prices. To do this, CMS would use an anchor factor and hospital weights. The anchor factor would equal the ratio of national average historical MS-DRG 469 anchored episode payments to national average historical MS-DRG 470 anchored episode payments. The national average would be based on episodes attributed to any CCJR eligible hospital. The resulting anchor factor would be the same for all participant hospitals. For each participant hospital, a hospital weight would be calculated using a formula, where episode counts are participant hospital-specific and based on the episodes in the three historical years used in target price calculations. CMS considered an alternative option of independently setting target prices for MS-DRG 470 and MS-DRG 469 anchored episodes without pooling them. However, hospital volume for MS-DRG 469 was substantially less than for MS-DRG 470. Thus, calculating target prices for MS-DRG 469 anchored episodes separately may result in too few historical episodes to calculate reliable target prices.

Discount Factor

When setting an episode target price for a participant hospital, CMS proposes to apply a discount to a hospital's hospital-specific and regional blended historical payments for a performance period. This discount would serve as Medicare's portion of reduced expenditures from the CCJR episode, with any episode expenditure below the target price potentially available as

reconciliation payments to the participant hospital where the anchor hospitalization occurred. This discount would be applied in order to establish the episode target price that would apply to the participant hospital's CCJR episodes during that performance period, and for which the hospital would be accountable for episode spending in relationship to the target price.

As mentioned earlier in this document, CMS proposes to phase in the financial responsibility of hospitals for repayment of actual episode spending that exceeds the target price starting in performance year two. In order to help hospitals transition to take on this responsibility, CMS would apply a reduced discount of one percent in performance year two for purposes of determining the hospital's responsibility for excess episode spending, but maintain the two percent discount for purposes of determining the hospital's opportunity to receive reconciliation payment for actual episode spending below the target price.

The reduced 1 percent discount would be applied for purposes of hospital repayment responsibility only in performance year two. The 2 percent discount for excess episode spending repayment responsibility would be applied for performance years three through five. Also, the discount for determination of reconciliation payment for episode spending below the target price would not deviate from 2 percent through performance years one through five.
Essentially, in performance year two, a hospital that achieves CCJR actual episode payments below a target price based on a 2 percent discount would retain savings below the target price. Hospitals whose CCJR actual episode payments exceed a target price based on a 1 percent discount would be responsible for making repayments to Medicare. Hospitals that achieve CCJR actual episode payments between a 2 percent and 1 percent discounted target price would neither receive reconciliation payments nor be held responsible for repaying Medicare.

Combining Pricing Features

For each performance year, CMS would set a target price for MS-DRG 469 episodes, and MS-DRG 470 episodes. CMS would calculate eight different target prices for each participant hospital for performance years one, three, four, and five, and 16 target prices for performance year two. These would include the same combinations as the other four performance years, but one set for determining potential reconciliation payments, and the other for determining potential Medicare repayment amounts, as part of the phasing in of the two-sided risk. Also, because different Medicare payment system updates become effective at two different times of the year, each MS-DRG would have one target price Jan. 1 through Sept. 30, and another for Oct. 1 through Dec. 31. CMS discusses the eight steps that would be used to calculate MS-DRG 469 and 470 anchored episode target prices for both Jan. 1 through Sept. 30, and Oct. 1 through Dec. 31, for each performance year. Each target price would reflect whether the hospital successfully submits data on the voluntary patient-reported outcome (PRO) measure or not (see section on CCJR quality measures for more detail). The determination of whether the hospital successfully submitted data on the PRO measure cannot be made until after the performance year ends and data is reported. Therefore, participant hospitals would be provided target prices for both scenarios whether they successfully submit data or not, and the determination will happen at the time of payment reconciliation. Also, target prices would be applied based on when the episode begins, even though the performance year to which an episode applies is based on when the episode ends.

Payment Reconciliation

After the completion of a performance year, CMS proposes to retrospectively calculate a participant hospital's actual episode performance. The agency would reconcile a participant hospital's CCJR actual episode payments against the target price two months after the end of the performance year. Each participant hospital's actual episode payment performance would be compared to its target prices. A participant hospital would have multiple target prices for episodes ending in a given performance year, based on the MS-DRG anchor, the performance year when the episode was initiated, when the episode was initiated within a given performance year, and whether the participant hospital successfully submitted total hip arthroplasty/total knee arthroplasty (THA/TKA) voluntary data. The applicable target price for each episode would be determined using these criteria, and the difference between each CCJR episode's actual payment. The relevant target price would be aggregated for all episodes for a participant hospital within the performance year, representing the raw net payment reconciliation amount (NPRA).

The NPRA would include adjustments to account for post-episode payment increases, and also include adjustments for stop-loss and stop-gain limits. Any NPRA amount greater than the proposed stop-gain limit would be capped at the stop-gain limit, and any NPRA amount less than the proposed stop-loss limit would be capped at the stop-loss limit. CMS would capture claims submitted by March 1, following the end of the performance year, and carry out the NPRA calculation to make a reconciliation payment or hold hospitals responsible for repayment, as applicable, in quarter two of that calendar year. To address issues of overlap with other CMS programs and final claims run-out time-frames, CMS would calculate the prior performance year's episode spending a second time during the following performance year's reconciliation process. This would occur approximately 14 months after the end of the prior performance year. The table below provides the proposed reconciliation timeframes for the model. The table in ***Appendix 3*** contains the current or forthcoming programs and models with potential overlap with CCJR.

TABLE 14—PROPOSED TIMEFRAME FOR RECONCILIATION IN CCJR

Model performance year	Model performance period	Reconciliation claims submitted by	Reconciliation payment or repayment	Second calculation to address overlaps and claims run-out	Second calculation adjustment to reconciliation amount
Year 1*	Episodes ending March 31, 2016 to December 31, 2016.	March 1, 2017	Q2 2017	March 1, 2018	Q2 2018
Year 2	Episodes ending January 1, 2017 through December 31, 2017.	March 1, 2018	Q2 2018	March 1, 2019	Q2 2019
Year 3	Episodes ending January 1, 2018 through December 31, 2018.	March 1, 2019	Q2 2019	March 2, 2020	Q2 2020
Year 4	Episodes ending January 1, 2019 through December 31, 2019.	March 2, 2020	Q2 2020	March 1, 2021	Q2 2021
Year 5	Episodes ending January 1, 2020 through December 31, 2020.	March 1, 2021	Q2 2021	March 1, 2022	Q2 2022

*Note that the reconciliation for Year 1 would not include repayment responsibility from CCJR hospitals.

Hospital Responsibility for Increased Post-episode Payments

When hospital repayment responsibility begins in the second performance year of CCJR, hospitals would be required to repay Medicare for episode expenditures that are greater than the applicable target price.

- *Stop-Loss Limit*
  To limit a hospital's overall repayment responsibility for the raw NPRA contribution to the repayment amount under this model, CMS proposes a 10 percent limit on the raw NPRA contribution to the repayment amount in performance year two and a 20 percent limit on the raw NPRA contribution to the repayment amount in performance year three and subsequent years, otherwise known as stop-loss limits. Ten percent provides an even transition with respect to maximum repayment amounts from performance year one, where the hospital bears no repayment responsibility, to the proposed stop-loss limit in performance years three through five of 20 percent. The proposed stop-loss percentage of 20 percent would be symmetrical in performance years three through five with the proposed limit on the raw NPRA contribution to reconciliation payments. CMS provides the following hypothetical example to illustrate how the proposed stop-loss percentage would be applied in these performance years:

  A participant hospital had ten episodes triggered by MS-DRG 469, with a target price for these episodes of $50,000. The hospital's actual spending for these episodes was $650,000. The hospital's raw NPRA would be capped at the 20 percent stop-loss limit of $100,000 (.2 x 10 x $50,000) so the hospital would owe CMS $100,000. In performance year three, the same hospital also has 100 episodes triggered by MS-DRG 470, with a target price for these episodes of $25,000. The hospital's actual spending for these 100 episodes was $2,800,000. The hospital's raw NPRA would be $300,000, an amount that would be due to CMS in full, as it would not be subject to the 20 percent stop-loss limit of $500,000 (.2 x 100 x $25,000).

  CMS estimates that the 10 percent stop-loss limit for year two would impact the amount of repayment due to the raw NPRA for about 11 percent of hospitals. For performance year three, the 20 percent stop-loss limit would affect only about 3 percent of hospitals. CMS notes that the stop-loss limit for years three through five where repayment responsibility is fully implemented is consistent with the BPCI Model 2 policy.

- *Stop-gain Limit*
  In determining what would constitute an appropriate reconciliation payment limit due to the raw NPRA, CMS believes it should provide significant opportunity for hospitals to receive reconciliation payments for greater episode efficiency that includes achievement of quality care and actual episode payment reductions below the target price, while avoiding creating significant incentives for sharply reduced utilization that could be harmful to beneficiaries. For all five performance years of the model, CMS proposes a limit on the raw NPRA contribution to the reconciliation payment of no more than 20 percent of the hospital's target prices for each MS-DRG multiplied by the number of the hospital's episodes for that MS-DRG. This proposed stop-gain limit is parallel to the 20 percent stop-loss limit proposed for performance year three and beyond. CMS notes that the stop-gain limit of 20 percent is also consistent with the BPCI Model 2 policy. Under the model, CMS expects that the proposed stop-gain limit could actually affect a few hospitals in each performance year.

There would be additional protections in place for rural, sole community, Medicare-dependent, and rural referral center hospitals with stop-loss of 3 percent for year two and 5 percent for years three through five.

Policies for Certain Hospitals to Further Limit Repayment Responsibility

CMS proposes additional protections for certain groups of hospitals that may have a lower risk tolerance and less infrastructure and support to achieve efficiencies for high-payment episodes, including rural hospitals, sole community hospitals, Medicare-dependent hospitals, and rural referral centers. These categories of hospitals often have special payment protections or additional payment benefits under Medicare because CMS recognizes the importance of preserving Medicare beneficiaries' access to care from them. CMS proposes a stop-loss limit of 3 percent of episode payments for these categories of hospitals in performance year two, and 5 percent for performance years three through five. CMS notes that this proposal does not impact the proposed stop-gain policy for these categories of hospitals.

Payment Methodology for Voluntary Submission of Data for Patient-Reported Outcome Measure

CMS proposes to adjust the episode payment methodology for participant hospitals that successfully submit THA/TKA voluntary data by reducing the discount percentage used to set the target price from 2.0 percent to 1.7 percent of expected episode spending based on historical CCJR episode data, or the voluntary reporting payment adjustment. The proposed payment policies with respect to reconciliation payment eligibility, and the discount percentage based on hospital voluntary data submission are summarized in the following table.

TABLE 7—RECONCILIATION PAYMENT ELIGIBILITY AND DISCOUNT PERCENTAGE INCLUDED IN THE TARGET PRICE FOR EACH PARTICIPANT HOSPITAL BASED ON QUALITY PERFORMANCE IN PERFORMANCE YEARS 3–5

Discount percentage included in target price/reconciliation payment eligibility	Meets thresholds for all 3 required quality measures	Does not meet thresholds for one or more of 3 required quality measures
Successfully submits THA/TKA voluntary data	1.7%/eligible	1.7%/ineligible.
Does not successfully submit THA/KA voluntary data	2.0%/eligible	2.0%/ineligible.

When CMS provides the episode target price to each participant hospital two times during the performance year, it would provide different target prices reflecting the 2.0 percent and 1.7 percent discounts. At the time of reconciliation for the performance year, it would determine which participant hospitals successfully reported the THA/TKA voluntary data for that performance year. For performance year two, when repayment responsibility is being phased in, for participant hospitals with successful THA/TKA voluntary data reporting, CMS would use a target price reflecting the 1.7 percent discount (compared with the 2.0 percent discount for non-reporting or unsuccessfully reporting hospitals) to determine if actual episode spending was below the target price, whereupon the participant hospital would receive a reconciliation payment if the quality thresholds on the three required measures are met.

In order to help hospitals transition to taking on repayment responsibility, CMS would apply a reduced discount of 0.7 percent for successful THA/TKA voluntary data reporting hospitals. For performance year one, when there is no repayment responsibility, CMS would use a target price

reflecting the 1.7 percent discount to determine if actual episode spending was below the target price, for hospitals with successful THA/TKA voluntary data reporting, whereupon it would receive a reconciliation payment if the quality thresholds on the three measures are met. Participant hospitals that successfully report the voluntary data would be subject to a lower repayment amount (except for performance year one when hospitals have no repayment responsibility) or a higher reconciliation payment (assuming the thresholds are met on the three required measures for reconciliation payment eligibility), than hospitals that do not successfully report the voluntary data.

Use of Quality Performance in the Payment Methodology

Incentivizing high-value care through episode-based payments for LEJR procedures is a primary objective of CCJR. Incorporating quality performance into the episode payment structure is an essential component of the CCJR model. CMS believes that it is important for the CCJR model to link the financial reward opportunity with achievement in quality of care for Medicare beneficiaries undergoing LEJR. Participating hospitals must meet certain quality performance standards in order to be eligible to receive a reconciliation payment under CCJR. Throughout the duration of the model, reconciliation payments would be made only to those CCJR hospital participants that meet or exceed a minimum measure result threshold.

To encourage care collaboration among multiple providers of patients undergoing THA and TKA, CMS proposes the following three measures to determine hospital quality of care, and eligibility for a reconciliation payment under the CCJR model:

- *Hospital-Level Risk-Standardized Complication Rate Following Elective Primary THA and/or TKA (NQF #1550)*: This outcome measure is the rate of complications occurring after THA and TKA during a 90-day period that begins with the date of the index admission for a specific hospital. An index admission is the hospitalization to which the complications outcome is attributed. The following outcomes are considered complications in this measure:

    - Acute myocardial infarction, pneumonia, or sepsis/septicemia within seven days of admission
    - Surgical site bleeding, pulmonary embolism, or death within 30 days of admission
    - Mechanical complications, periprosthetic joint infection or wound infection within 90 days of admission.

- *Hospital-Level 30-Day, All-Cause Risk-Standardized Readmission Rate (RSRR) Following Elective Primary Total THA and/or TKA*: The objective of this measure is to assess readmission from any cause within 30 days of discharge from the hospital following elective primary THA and TKA. CMS believes that a risk-adjusted readmission outcome measure can provide a critical perspective on the provision of care, and support improvements in care for the Medicare patient population following THA/TKA hospitalization.

- *The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey (NQF #0166):* The HCAHPS is a survey instrument and data collection methodology for measuring patients' perceptions of their hospital experience. It asks recently discharged patients 32 questions about aspects of their hospital experience. Eleven HCAHPS measures (seven composite measures, two individual items, and two global items) are currently publicly reported on the Hospital Compare website for each hospital participating in the Hospital Inpatient Quality Reporting (HIQR) Program.

Methodology to Link Quality and Payment

CMS is proposing that in order for a hospital in the CCJR model to receive a reconciliation payment for the applicable performance year, its measure results must meet or exceed certain thresholds compared to the national hospital measure results calculated for all HIQR participant hospitals. Thresholds for performance would increase over the lifetime of the model to incentivize continuous improvement. Specifically, in order for a participant hospital to qualify for a reconciliation payment, it must meet or exceed the 30th percentile benchmark for each of the three proposed quality measures in performance years one through three. In performance years four and five, a hospital must meet or exceed the 40th percentile benchmark for the proposed quality measures. Participant hospitals would have an additional financial incentive to successfully submit data on a patient-reported functional outcome measure beginning in year one.

Performance Periods

In order to align the CCJR program with other CMS hospital quality and public reporting programs, CMS proposes a three-year rolling performance period for the THA/TKA complication and readmission measures because it yields the most consistently reliable and valid measure results, and because hospitals are intimately familiar with these measures.

TABLE 17—SUMMARY OF QUALITY MEASURE PERFORMANCE PERIODS BY YEAR OF THE CCJR MODEL

Measure title	CCJR model year				
	1st	2nd	3rd	4th	5th
THA/TKA Complication*	April 1, 2013–March 31, 2016.	April 1, 2014–March 31, 2017.	April 1, 2015–March 31, 2018.	April 1, 2016–March 31, 2019.	April 1, 2017–March 31, 2020.
THA/TKA** Readmission	July 1, 2013–June 30, 2016.	July 1, 2014–June 30, 2017.	July 1, 2015–June 30, 2018.	July 1, 2016–June 30, 2020.	July 1, 2017–June 30, 2016.
HCAHPS***	July 1, 2015–June 30, 2016.	July 1, 2016–June 30, 2017.	July 1, 2017–June 30, 2018.	July 1, 2018–June 30, 2019.	July 1, 2019–June 30, 2020.

*Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1550).
**Hospital-Level Risk-Standardized Readmission Rate (RSRR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1551).
***HCAHPS (NQF #0166) Survey.

For the HCAHPS Survey measure, CMS would continue to use a four-quarter performance period as in the HIQR program, but would not align with the program performance period. CMS initially considered using the same HIQR program performance period for the HCAHPS survey measures, but since the HCAPHS survey results are not available until the third quarter of each year, policy goals like calculating reconciliation payment adjustments in a timely fashion during the second quarter of each year would not be met. HCAHPS survey scores would be calculated from four consecutive quarters of survey data.

Payment Methodology Adjustment for Voluntary Submission of Data for Patient-Reported Outcome Measure

During its consideration of quality metrics for the CCJR model, CMS examined the feasibility of linking voluntary data submission of PRO data as a way of incentivizing participant hospitals under the episode payment model to participate in this voluntary submission of data.

CMS believes the proposed voluntary reporting payment adjustment provides the potential for increased financial benefit for participant hospitals due to a higher target price (that reflects a lower discount percentage) that successfully report the measure. In general, participant hospitals that meet the performance thresholds for the quality measures, reduce actual episode spending below the target price, and successfully report the voluntary data on the measures would be eligible to retain an additional 0.3 percent of the reduced episode expenditures. CMS estimates the value of this discount reduction, on average, to be about $75 per LEJR episode at a participant hospital, which would be sufficient to pay hospitals for the resources required to survey beneficiaries pre- and post-operatively.

Data Collection

THA/TKA voluntary data submission must occur within 60 days of the end of the most recent data collection period. To fulfill THA/TKA voluntary data collection criteria for performance year one, only preoperative data collection and submission on at least 80 percent of eligible elective primary THA/TKA patients is required. To successfully submit THA/TKA voluntary data for performance years two through five, hospitals must submit both preoperative and post-operative patient-reported outcome (PRO) data on at least 80 percent of elective primary THA/TKA patients. Having 80 percent of the eligible elective primary THA/TKA patients will enable an accurate and reliable assessment of patient-reported outcomes for use in measure development. Hospitals volunteering to submit THA/TKA data will be required to submit pre-operative data on all eligible patients and postoperative data elements only on those patients at least 366 days out from surgery. ***Appendix 4*** (Table 16 of the proposed rule) summarizes the performance periods for preoperative and postoperative THA/TKA voluntary data. The voluntary reporting payment adjustment would be available for all years of the model, unless CMS finds the THA/TKA measure to be unfeasible or has adequately developed the measure such that continued voluntary data collection is no longer needed for measure development. In these situations, CMS would notify participant hospitals that the voluntary reporting payment adjustment is no longer available as it would cease collecting the data.

Waivers of Medicare Program Rules

CMS believes it may be necessary and appropriate to provide additional flexibilities to hospitals participating in CCJR, as well as other providers that furnish services to beneficiaries in CCJR episodes. The purpose of such flexibilities would be to increase LEJR episode quality and decrease episode spending. These waivers of program rules would apply to the care of beneficiaries who are in CCJR episodes at the time when the waiver is used to bill for a service that is furnished to the beneficiary, even if the episode is later canceled. If a service is found to have been billed and paid by Medicare under circumstances only allowed by a program rule waiver for a beneficiary not in the CCJR model at the time the service was furnished, CMS

would recoup payment for that service from the provider or supplier who was paid, and require that provider and supplier to repay the beneficiary for any coinsurance previously collected.

- *Post-Discharge Home Visits*: Under this waiver, only beneficiaries who meet all program requirements to receive home health services would be eligible for coverage of these health services without being homebound. Under the proposal, up to nine post-discharge visits could be billed and paid during each 90-day post-anchor hospitalization CCJR episode. The visit would be billed under a HCPCS code created for the model. CMS is not proposing to waive the homebound requirement under CCJR for several reasons, including the fact that many beneficiaries would meet the homebound requirement for home health services immediately following discharge, so they could receive medically necessary home health services under existing program rules. However, for the CCJR model, CMS would waive the ''incident to'' rule, to allow a CCJR beneficiary who does not qualify for home health services to receive post-discharge visits in his or her home or place of residence any time during the episode. Licensed clinicians, such as nurses, either employed by a hospital or not, would furnish the service under the general supervision of a physician, who may be either an employee or a contractor of the hospital.

- *Telehealth Services*: For CCJR, CMS proposes to waive the geographic site requirements allowing telehealth services to be furnished to eligible individuals when they are located at one of the eight originating sites at the time the service is furnished via a telecommunications system, but without regard to the site meeting one of the geographic site requirements. CMS also proposes to waive the requirement that the eligible telehealth individual be in an originating site when receiving telehealth services in his or her home or place of residence. Like the telehealth waiver for BPCI, CMS proposes to waive the geographic site requirements that limit telehealth payment to services furnished within specific types of geographic areas or in an entity participating in a federal telemedicine demonstration project approved as of Dec. 31, 2000. Waiver of this requirement would allow beneficiaries located in any region to receive services related to the episode to be furnished via telehealth, as long as all other Medicare requirements for telehealth services are met. Telehealth visits under this model cannot be a substitute for in-person home health visits.

- *Skilled Nursing Facility (SNF) Three-day Rule:* Because of the potential benefits CMS sees for participating CCJR hospitals, their provider partners, and beneficiaries, it would waive, in certain instances, the SNF three-day rule for coverage of a SNF stay following the anchor hospitalization under CCJR from years two through five of the model when repayment responsibility for actual episode spending that exceeds the target price begins. CMS believes that this waiver is necessary to the model test so that participant hospitals can redesign care throughout the episode continuum of care extending to 90 days post-discharge from the anchor hospital stay in order to maximize quality and hospital financial efficiency, as well as reduce episode spending under Medicare. CMS would not waive this requirement in performance year one, when participating hospitals are not responsible for excess actual episode spending, because the agency is concerned that Medicare would be at full risk under the model for increased episode spending because

there is no incentive for hospitals to closely manage care. Participant hospitals would be required to only discharge a CCJR beneficiary under this proposed waiver to a SNF rated with an overall rating of three stars or higher. Beneficiaries must not be discharged prematurely to SNFs, and they must be able to exercise their freedom of choice without patient steering.

Proposed Financial Arrangements with CCJR Collaborators

CMS believes that participant hospitals may wish to enter into financial arrangements with providers and suppliers caring for beneficiaries in CCJR episodes in order to align the financial incentives of those providers and suppliers with the model goals of improving quality and efficiency for LEJR episodes. These "CCJR collaborators" would directly furnish related items or services to a beneficiary during the episode and/or specifically participate in CCJR model LEJR episode care redesign activities. In addition to playing a role in the participant hospital's episode spending or quality performance, CCJR collaborators must directly furnish services to CCJR beneficiaries in order to receive a gainsharing payment as result of their financial arrangement, or ''CCJR Sharing Arrangement'' with the participant hospital. The terms of each CCJR Sharing Arrangement would be set forth in a written agreement between the participant hospital and the CCJR collaborator. Since the proposed episode duration is 90 days following discharge from the anchor hospital stay and they are broadly based, many providers and suppliers other than the participant hospital will furnish related services to beneficiaries during care episodes. CMS believes that a participant hospital that may receive a reconciliation payment or have to repay Medicare may also want to enter into financial arrangements with these providers and suppliers to share risks and rewards under CCJR.

Sharing Arrangements

CMS proposes that a ''CCJR Sharing Arrangement'' would be a financial arrangement contained in a Participation Agreement to share only the following:

- CCJR reconciliation payments
- The participant hospital's internal cost savings
- The participant hospital's responsibility for repayment to Medicare

CMS proposes that each CCJR Sharing Arrangement must include and set forth in writing at a minimum:

- A specific methodology and accounting formula for calculating and verifying internal cost savings if the hospital elects to share internal cost savings through gainsharing payments with CCJR collaborators
- Description of the methodology and accounting formula for calculating the percentage or dollar amount of reconciliation payments
- Description of the methodology, frequency or dates of distribution, and accounting formula for distributing and verifying any and all gainsharing payments
- Description of the arrangement between the participant hospital and the CCJR collaborator regarding alignment payments

- Provision requiring the participant hospital to recoup gainsharing payments paid to CCJR collaborators if these payments were based on the submission of false or fraudulent data
- Plans regarding care redesign, changes in care coordination, or delivery that are applied to the participant hospital or CCJR collaborators or both, and any description of how success will be measured
- Management and staffing information

Also:

- The participant hospital must maintain records identifying all CCJR collaborators.
- All CCJR Sharing Arrangements must require compliance, from both the participant hospital and the CCJR collaborator, with the proposed polices regarding beneficiary notification.

Beneficiary Financial Incentives

Because the proposed broadly defined LEJR episodes extend 90-days post-discharge from the anchor hospital stay, we believe that participant hospitals caring for CCJR beneficiaries may want to offer beneficiary incentives to encourage beneficiary adherence to recommended treatment and active patient engagement in recovery. These incentives should be closely related to the provision of high-quality care during the episode, advance a clinical goal for a CCJR beneficiary, and should not serve as inducements to beneficiaries to seek care from the participant hospital or other specific suppliers and providers. Such incentives may help participant hospitals reach their quality and efficiency goals for CCJR episodes, while benefiting beneficiaries' health and the Medicare Trust Fund if hospital readmissions and complications are reduced while recovery continues uninterrupted or accelerates.

Gainsharing Payments

Gainsharing payments are defined as those that are made from a participant hospital to a CCJR collaborator pursuant to a CCJR Sharing Arrangement. CMS proposes to define this payment as an alignment payment. A gainsharing payment may only be composed of the following:

- Reconciliation payments
- Internal cost savings
- Both

CMS proposes extensive conditions and restrictions concerning gainsharing and alignment payments made pursuant to a CCJR Sharing Arrangement, in the proposed rule. These conditions and restrictions can be found in ***Appendix 5*** of this document. A participant hospital must retain at least 50 percent of its responsibility for repayment to CMS. Also, a CCJR collaborator would not be able to make an alignment payment to a participant hospital in an amount greater than 25 percent of the hospital's reconciliation repayment amount.

Records Retention

CMS proposes to require participant hospitals and CCJR collaborators to comply with audit and document retention requirements similar to those required by the Medicare Shared Savings Program, BPCI Model 2, and other Innovation Center models. Under the agreement, the

participant hospital and CCJR collaborator must sufficiently enable the audit, evaluation, inspection, or investigation of the participant hospital's compliance, as well as the compliance of any CCJR collaborator. Also, participant hospitals and CCJR collaborators would be required to maintain such books, contracts, records, documents, and other evidence for a period of 10 years from the last day of participation in the CCJR model. If there has been a dispute or allegation of fraud, records must be maintained for an additional six years from the date of any resulting final resolution of the dispute or allegation of fraud or similar fault.

Beneficiary Incentives

CMS proposed to include in the CCJR model certain in-kind patient engagement incentives to the beneficiary, subject to the following conditions:

- The incentive must be provided by the participant hospital to the beneficiary during the CCJR episode of care.
- There must be a reasonable connection between the item or service and the beneficiary's medical care.
- The item or service must be a preventive care item or service or an item or service that advances a clinical goal for a CCJR beneficiary.
- The item or service must not be more valuable than necessary.
- Incentives should not serve as inducements to beneficiaries to seek care from the participant hospital or other specific suppliers and providers.

Further, participant hospitals would be required to maintain for a period of ten years, contemporaneous documentation of such items and services furnished that exceed $10, including the date and identity of the beneficiary to whom the item or service was provided. Items and services involving technology provided to beneficiaries may not exceed $1,000 in retail value at the time of donation for any beneficiary in any CCJR episode. Items of technology exceeding $50 in retail value at the time of donation must remain the property of the participant hospital and must be retrieved from the beneficiary at the end of the episode, with the documentation of the date of retrieval.

Fraud and Abuse Laws

Certain arrangements between and among participant hospitals and third parties or beneficiaries may implicate the civil monetary penalty law, the Federal anti-kickback statute, or the physician self-referral prohibition. In many cases, arrangements that implicate these laws can be structured to comply with them by using existing safe harbors and exceptions. Section 1115A of the Act authorizes the HHS Secretary to waive certain specified fraud and abuse laws as may be necessary solely for the purposes of testing payment models. A waiver is not needed for an arrangement that does not implicate the fraud and abuse laws or that implicates them, but fits within an existing exception or safe harbor.

These waivers of certain program rules for providers and suppliers furnishing services to CCJR beneficiaries may be appropriate to offer more flexibility than under existing Medicare rules so that they may provide appropriate, efficient care for beneficiaries. The HHS Secretary will consider whether waivers of certain fraud and abuse laws are necessary to test the CCJR model as the model develops. CMS believes that they are necessary to make reconciliation payments to

or recoup payments from participant hospitals as a result of the NPRA for each performance year, as well as to exclude beneficiary cost-sharing from these reconciliation payments or recoupments. Such waivers would be promulgated separately from this proposed regulation by the Office of Inspector General (OIG) and CMS.

Monitoring and Beneficiary Protection

CMS believes that the CCJR model will improve beneficiary access and outcomes, but these same opportunities could be used to try to steer beneficiaries into lower cost services without an appropriate emphasis on maintaining or increasing quality. CMS believes that existing Medicare provisions can be effective in protecting beneficiary freedom of choice and access to appropriate care under the CCJR model. However, because the CCJR model is designed to promote efficiencies in the delivery of all care associated with LEJR procedures, providers may seek greater control over the continuum of care and attempt to direct beneficiaries into care pathways that save money at the expense of beneficiary choice or outcomes. Therefore, CMS acknowledges that some additional safeguards may be necessary under the CCJR model as providers are simultaneously seeking opportunities to decrease costs and utilization.

- *Beneficiary Choice:* Individual beneficiaries will not be able to opt out of the CCJR model when they receive care from a participant hospital in the model. This proposed payment model does not limit the beneficiary's ability to choose among Medicare providers or the range of services available. Although the proposed model would allow participant hospitals to enter into CCJR sharing arrangements with certain providers, and these preferred providers may be recommended to beneficiaries as long as those recommendations are made within the constraints of current law, hospitals may not restrict beneficiaries to any list of preferred or recommended providers that surpass any restrictions that already exist under current statutes and regulations.

- *Beneficiary Notification:* CMS believes that beneficiary notification and engagement is essential because there will be a change in the way participating hospitals are paid. CMS believes that appropriate beneficiary notification should: explain the model, advise patients of their clinical needs and their care delivery choices, and clearly specify that any non-hospital provider holding a risk-sharing agreement with the hospital should be identified to the beneficiary as a ''financial partner" of the hospital for the purposes of LEJR services. Under the proposal, participating hospitals must require all providers and suppliers who execute a CCJR Sharing Arrangement with a participant hospital to share certain notification materials, to be developed or approved by CMS, that detail this proposed payment model before they order an admission for joint replacement for a Medicare FFS patient who would be included under the model. In instances where a participant hospital does not have CCJR Sharing Arrangements with providers or suppliers that furnish services to beneficiaries during a CCJR episode of care, or where the admission for joint replacement for a patient who would be included under the model was ordered by a physician who does not have a CCJR Sharing Arrangement, the beneficiary notification materials must be provided by the participant hospital.

- *Monitoring for Quality of Care:* CMS may monitor arrangements between participant hospitals and their CCJR collaborators to ensure that such arrangements do not result in the denial of medically necessary care or other program or patient abuse. CMS believes that is has the authority and responsibility to audit the medical records and claims of participating hospitals and their CCJR collaborators in order to ensure that beneficiaries receive medically necessary services. CMS believes that requiring participating hospitals to engage patients in shared decision making is the most important safeguard to prevent inappropriate recommendations of lower cost care. This requirement can be best effected by requiring hospitals to make this a condition of their CCJR Sharing Arrangements. Therefore, CMS is proposing to require that participant hospitals must, as part of discharge planning, account for potential financial bias by providing patients with a complete list of all available post-acute care options in the service area consistent with medical need, including beneficiary cost-sharing and quality information (where available and when applicable). These proposed requirements for CCJR participant hospitals would supplement the existing discharge planning requirements under the hospital conditions of participation.

Data Sharing Specifications

Beneficiary Claims Data

Hospitals vary with respect to the kinds of beneficiary claims information that would be most helpful. While many hospitals located in MSAs that are selected for participation in the CCJR model may have the ability to analyze raw claims data, other hospitals may find it more useful to have a summary of these data. Therefore, CMS proposes to make beneficiary claims information available through two formats:

- First, for participant hospitals that lack the capacity to analyze raw claims data, CMS would provide summary beneficiary claims data reports on beneficiaries' use of healthcare services during the baseline and performance periods. The summary reports will provide tools to monitor, understand, and manage utilization and expenditure patterns as well as to develop, target, and implement quality improvement programs and initiatives. The summary claims data would encompass the total expenditures and claims for an LEJR episode, including the procedure, inpatient stay, and all related care covered under Medicare Parts A and B within the 90 days after discharge for the hospital's beneficiaries whose anchor diagnosis at discharge was either MS-DRG 469 or MS-DRG 470.

- Second, for hospitals with a capacity to analyze raw claims data, CMS would make more detailed beneficiary-level information available in accordance with established privacy and security protections.

- For the baseline period, and on a quarterly basis during a hospital's performance period, CMS proposes to provide participant hospitals with an opportunity to request line-level claims data for each episode that is included in the relevant performance year.

Aggregate Regional Data
CMS believes it will be necessary to provide comparable aggregate expenditure data available for all claims associated with MS-DRG 469 and MS-DRG 470 for the census region in which the participant hospital is located. These data would not include beneficiary-identifiable claims data.

Timing and Period of Baseline Data
CMS proposes to make baseline data available to hospitals participating in CCJR no sooner than 60 days after the model's effective date of Jan. 1, 2016. This data would be available to CCJR hospitals within 60 days of CMS's receipt of the request, which would not be accepted until after the model has begun. Also, CMS proposes to make baseline data available for up to a three-year period.

Frequency and Period of Claims Data Updates
CMS proposes to make updated claims data available to hospitals upon receipt of a request for the information that meets its requirements to ensure the applicable Health Insurance Portability and Accountability Act (HIPAA) conditions for disclosure have been met, on a quarterly basis. Beneficiary-identifiable and aggregate claims data would be available representing up to six quarters. CMS notes that it intends for the data for this model to be consistent with the performance year (Jan. 1 through Dec. 31). To accomplish this for the first year of CCJR (2016), CMS would provide, upon request and in accordance with the HIPAA Privacy Rule, claims data from Jan. 1, 2016, to June 30, 2017, on as frequently as a running quarterly basis, as claims are available. For each quarter and extending through June 30, 2017, participants would receive data for up to the current quarter and all of the previous quarters going back to Jan. 1, 2016.

Sharing Beneficiary-Identifiable Data
Under the proposal, participant hospitals would be financially responsible for services that may have occurred outside of the hospital during the 90-day post-discharge period. Based on its experiences with data sharing in other programs and models, CMS proposes a strategy for notifying beneficiaries of claims data sharing in the proposed rule, and providing meaningful beneficiary choice over claims data sharing with the participant hospitals in CCJR. Thus, CMS proposes to use an ''optout'' approach to provide beneficiaries with the opportunity to decline claims data sharing directly through 1-800-Medicare, rather than through the participant hospital. CMS also proposes to provide advance notification to all Medicare beneficiaries about the opportunity to decline claims data sharing with entities participating in CMS programs and models through CMS materials such as the *Medicare & You* handbook. CMS clarifies that a beneficiary who chooses to opt out of claims data sharing is only opting out of the data sharing portion of the model. The decision to opt out does not otherwise limit CMS's use of the beneficiary's data, whether the beneficiary can initiate an episode, inclusion in quality measures, or inclusion in reconciliation calculations.

Proposed Adjustments for Overlaps with Other CMS Programs
There is a possibility for overlap between CCJR episodes and shared savings models. CMS displays the current or forthcoming programs and models with potential overlap with CCJR in Table 15 of the proposal (***Appendix 3*** of this document).

CCJR Beneficiary Overlap with Bundled Payments for Care Improvement (BPCI) Episodes
CMS proposes to exclude from selection for participation in the CCJR payment model those geographic areas where 50 percent or more of LEJR episodes are initiated at acute care hospitals testing the LEJR episode in BPCI in Models 1, 2, or 4 as of July 1, 2015. Although the agency believes the proposal will mitigate the overlap of CCJR beneficiaries with BPCI episodes, there may still be instances of model overlap that need to be accounted for. In scenarios in which there is overlap of CCJR beneficiaries with any BPCI LEJR episodes, CMS proposes that the BPCI LEJR episode under Models 1, 2, 3, or 4 take precedence, and the CCJR episode would be canceled (or never initiated). CMS would exclude the CCJR episode from the CCJR participant hospital's reconciliation calculations where it compares actual episode payments to the target price under the CCJR model.

- *Accounting for CCJR Reconciliation Payments and Repayments in Other Models and Programs*: CMS proposes to calculate beneficiary-specific payments for CCJR episodes to allow for other programs and models to determine the total cost of care for overlapping beneficiaries. CMS would perform the reconciliation calculations for CCJR hospitals and make information about the reconciliation or repayment amounts available to other programs and models that begin reconciliation calculations after CCJR. In these cases, CMS would not make separate payments to, or collect repayments from, participating CCJR hospitals for each individual episode, but, would instead, make a single aggregate reconciliation payment or repayment determination for all episodes for a single performance year. CMS proposes to conduct the first reconciliation based on claims data available two months after the end of the performance year, and a second calculation based on claims data available 14 months after the end of a performance year to account for claims run-out and potential overlap with other models.

- *Accounting for Per-Beneficiary-Per-Month (PBPM) Payments in the Episode Definition*: PBPM payments to providers for new or enhanced services include the following five CMS models (displayed in Table 15 of the proposed rule):

    - Comprehensive Primary Care Initiative (CPCi)
    - Multi-payer Advanced Primary Care Practice (MAPCP)
    - Oncology Care Model (OCM)
    - Million Hearts
    - Medical Care Choices Model

- CMS considers clinically related those services paid by PBPM payments that are for the purpose of care coordination and care management of any beneficiary diagnosis or hospital readmission not excluded from the CCJR episode definition. CMS would determine whether the services paid by PBPM payments are excluded from the CCJR episode on a model-by-model basis based on their funding source and clinical relationship to CCJR episodes. PBPM model payments that CMS determines are clinically unrelated would be excluded from target process and actual episode payments, regardless of the funding mechanism or diagnosis codes on claims for those payments. If a model's PBPM payments are for new or enhanced services that are clinically related to

the CCJR episode, and the PBPM payment is funded through the Medicare Part A or Part B Trust Fund, the services paid by the PBPM payment would be included if they meet the proposed episode definition for the CCJR model. PBPM payments funded through Center for Medicare and Medicaid Innovation's (CMMI's) appropriation would always be excluded, regardless of whether they are clinically related to the episode. Services paid by PBPM payments under the MAPCP model would not be excluded from CCJR episodes.

Overlap with Shared Savings Programs and Total Cost of Care Models

There are several Accountable Care Organization (ACO) and other Innovation Center models that hold providers accountable for the total cost of care over the course of an extended period of time or episode of care by applying various payment methodologies. Under the proposal, CMS would simultaneously allow beneficiaries to participate in broader population-based and other total cost of care models, as well as episode payment models that target a specific episode of care with a shorter duration, such as CCJR. CMS believes that when this overlap occurs, it is most appropriate to attribute Medicare savings accrued during the CCJR time period to the fullest extent possible. In order to ensure this, CMS proposes the following policies:

- *Total cost of care calculations under non ACO total cost of care models*: These models would be adjusted to account for beneficiaries that are aligned to model participants, and whose care is included in CCJR in order to ensure that Medicare savings achieved under the model are not paid back through shared savings or other performance-based payment. CMS proposes that the non-ACO total cost of care models to which this policy would apply would include CPCi, OCM, and MAPCP.

- *Overlap with* the Medicare Shared Savings Program *(MSSP) and other ACO models*: Given the operational complexities and requirements of the MSSP reconciliation process, it is not feasible for the MSSP to make an adjustment to account for the discount to Medicare under a CCJR episode under existing program rules and processes. However, for consistency among ACO models and programs, given that the ACO models are generally tested for the purpose of informing future potential changes to MSSP, CMS believes that the ACO model overlap adjustment policy should be aligned with the MSSP policy. Under CCJR, CMS would make an adjustment to the reconciliation amount to account for any of the applicable discount for an episode resulting in Medicare savings paid back through shared savings under MSSP or any other ACO model, ***but only when a CCJR participant hospital also participates in the ACO, and the beneficiary in the CCJR episode is also aligned to that ACO***. CMS notes this adjustment would be necessary to ensure that the applicable discount under CCJR is not reduced because a portion of that discount is paid out in shared savings to the ACO and thus, indirectly, back to the hospital.

CMS would not make an adjustment under CCJR when a beneficiary receives an LEJR procedure at a participant hospital and is aligned to an ACO in which the hospital is not participating. While this would leave overlap unaccounted for, CMS does not believes it would be appropriate to hold the hospital that managed the beneficiary during the episode through a

CCJR adjustment responsible for repayment, given that the participant hospital may have engaged in care redesign and reduced spending during the episode. However, CMS recognizes that as proposed, this policy would allow an unrelated ACO full credit for the Medicare savings achieved during the episode. CMS believes that the operational complexities and requirements of the MSSP make it infeasible for it to make an adjustment in such cases.

Appeals and Reconciliations

CMS proposes to institute appeals processes for the CCJR model that would allow participant hospitals to appeal matters related to reconciliation and payment, as well as non-payment related issues, such as enforcement matters.

- *Payment:* If the CCJR Reconciliation Report indicates the reconciliation amount is positive, CMS would issue a payment for that amount to the hospital within 30 calendar days**,** unless the hospital selects to pursue the calculation error and reconsideration review processes. Beginning in performance year two, if the CCJR Reconciliation Report indicates the NPRA is negative, the participant hospital would make payment for the absolute value of that amount to CMS within 30 calendar days. If the participant hospital does not issue payment within that allotted time, CMS will issue a demand letter requiring payment be made immediately. If the participant hospital fails to pay CMS the full amount owed by the date indicated in the demand letter, CMS will recoup owed monies from the participant hospital's present and future Medicare payments to collect all monies due. Although CMS proposed that a participant hospital may enter into financial arrangements with CCJR collaborators that allow for some risk sharing, the participant hospital would be solely liable for the repayment of the negative repayment amount to CMS. If the hospital fails to repay CMS in full for all monies owed, it would invoke all legal means to collect the debt, including referral of the remaining debt to the United States Department of the Treasury.

- *Calculation Error:* Participant hospitals would review their CCJR reconciliation report and be required to provide written notice of any error, in a calculation error form that must be submitted in a form and manner specified by CMS. If the hospital does not provide this notice, the reconciliation report would be deemed final within 30 calendar days after it is issued, and CMS would proceed with payment or repayment. If CMS receives a timely notice of an error in the calculation, it would respond in writing within 30 calendar days to either confirm or refute the calculation error, although CMS would reserve the right to an extension upon written notice to the participant hospital. CMS proposes that if a participant hospital does not submit timely notice of calculation error, it would be precluded from later contesting any of the following matters contained in the CCJR reconciliation report for that performance year:

    - Any matter involving the calculation of the participant hospital's reconciliation amount or repayment amount as reflected on a CCJR reconciliation report
    - Any matter involving the calculation of NPRA
    - The calculation of the percentiles of quality measure performance to determine eligibility to receive a reconciliation payment

- The successful reporting of the voluntary PRO THA/TKA data to adjust the reconciliation payment

Dispute Resolution

CMS notes that there is currently no administrative or judicial review under sections 1869 or 1878 of the Act or otherwise for the following:

- The selection of models for testing or expansion under section 1115A of the Act
- The selection of organizations, sites, or participants to test those models selected
- The elements, parameters, scope, and duration of such models for testing or dissemination
- Determinations regarding budget neutrality
- The termination or modification of the design and implementation of a model under subsection 1115A(b)(3)(B)

A participant hospital would be able to appeal an initial determination that is not precluded from administrative or judicial review by requesting reconsideration review by a CMS official within 10 days of the notice of the initial determination. Initial determinations that are not precluded from administrative or judicial review would include the involuntary termination of a participant hospital's participation in the CCJR model. Further, only a participant hospital may utilize the dispute resolution process, and in order to access this process, the hospital must have timely submitted a calculation error form. If the participant hospital submits a calculation error form, and is dissatisfied with CMS's response, it would be permitted to request a reconsideration review by a CMS reconsideration official. Within 15 calendar days of receiving the request, the CMS reconsideration official would send the hospital a Scheduling Notice, containing the date of the review, which would occur no later than 30 days after the date of the Scheduling Notice. A final and binding written determination would be issued within 30 days of the review. For matters unrelated to payment, such as termination from the model, the participant hospital would not need to submit a calculation error form. CMS proposes to require the participant hospital to timely submit a request for reconsideration review.

Enforcement Mechanisms

Given that participant hospitals may receive reconciliation payments, and choose to distribute or share those payments with other CCJR collaborators, CMS believes that enhanced scrutiny and monitoring of participant hospitals and collaborators under the CCJR model is necessary and appropriate. CMS proposes an enforcement structure that would be consistent with other CMMI models. CMS believes that Model 2 of the BPCI initiative is an appropriate model for comparison, given that Model 2 and CCJR share many of the same policy characteristics, particularly with respect to episode definition.

CMS would have enforcement mechanisms in place for use against a participant hospital that:

- Does not comply with the CCJR model requirements
- Is identified as noncompliant via CMS's monitoring of the model
- Takes any action that threatens the health or safety of patients
- Avoids at-risk Medicare beneficiaries

- Avoids patients on the basis of payer status
- Is subject to sanctions or final actions of an accrediting organization or federal, state, or local government agency that could lead to the inability to comply with the requirements and provisions of the BPCI agreement
- Takes or fails to take any action that CMS determines for program integrity reasons is not in the best interests of the BPCI initiative
- Is subject to action by HHS (including OIG and CMS) or the Department of Justice to redress an allegation of fraud or significant misconduct

CMS would have the option to use any one or more of the following enforcement mechanisms, which could be instituted and applied in any order, as is consistent with other CMMI models:

- *Warning letter*: Informs participant hospitals of the issue(s) identified by CMS leading to the issuance of the document.
- *Corrective Action Plan:* CMS would have the authority to request a corrective action plan from participant hospitals.
- *Reduction or Elimination of Reconciliation Amount:* CMS would have the authority to reduce or eliminate a participant hospital's reconciliation amount based on noncompliance with the model's requirements.
- *Termination:* CMS believes that, in contrast to other CMS models, termination from the CCJR model would contradict its design. While termination is a remedy unlikely to be frequently used, it leaves open the possibility that in extremely serious circumstances termination might be appropriate, and should be included as an available enforcement option. Should a hospital be terminated from the CCJR model, CMS proposes that the hospital would remain liable for all negative NPRA generated from episodes of care that occurred prior to termination. CMS may terminate CCJR participation of a hospital or collaborator for failure to comply with any of the requirements of the CCJR model.

Under the CCJR model, CMS proposes that it would have the following enforcement mechanisms available for use against participant hospitals and any entity or individual furnishing a service to a beneficiary during a CCJR episode, where the participant hospital or such entity or individual:

- Does not comply with the CCJR model requirements
- Is identified as noncompliant via CMS's monitoring of the model or engages in behavior related to any of the reasons previously described that apply to the BPCI initiative

More Information
Read the proposed rule is published in the July 14, 2015, *Federal Register*.

Appendix 1 - MSAs Included in the CCJR Model

MSA	MSA Name
10420	Akron, OH.
10740	Albuquerque, NM.
11700	Asheville, NC.
12020	Athens-Clarke County, GA.
12420	Austin-Round Rock, TX.
13140	Beaumont-Port Arthur, TX.
13900	Bismarck, ND.
14500	Boulder, CO.
15380	Buffalo-Cheektowaga-Niagara Falls, NY.
16020	Cape Girardeau, MO-IL.
16180	Carson City, NV.
16740	Charlotte-Concord-Gastonia, NC-SC.
17140	Cincinnati, OH-KY-IN.
17820	Colorado Springs, CO.
17860	Columbia, MO.
18580	Corpus Christi, TX.
19500	Decatur, IL.
19740	Denver-Aurora-Lakewood, CO.
20020	Dothan, AL.
20500	Durham-Chapel Hill, NC.
21780	Evansville, IN-KY.
22420	Flint, MI.
22500	Florence, SC.
22660	Fort Collins, CO.
23540	Gainesville, FL.
23580	Gainesville, GA.
24780	Greenville, NC.
25420	Harrisburg-Carlisle, PA.
26300	Hot Springs, AR.
26900	Indianapolis-Carmel-Anderson, IN.
28140	Kansas City, MO-KS.
28660	Killeen-Temple, TX.
29820	Las Vegas-Henderson-Paradise, NV.
30700	Lincoln, NE.
31080	Los Angeles-Long Beach-Anaheim, CA.
31180	Lubbock, TX.
31540	Madison, WI.
32780	Medford, OR.
32820	Memphis, TN-MS-AR.
33100	Miami-Fort Lauderdale-West Palm Beach, FL.
33340	Milwaukee-Waukesha-West Allis, WI.
33700	Modesto, CA.
33740	Monroe, LA.
33860	Montgomery, AL.
34940	Naples-Immokalee-Marco Island, FL.
34980	Nashville-Davidson—Murfreesboro—Franklin, TN.
35300	New Haven-Milford, CT.
35380	New Orleans-Metairie, LA.

Appendix 1 - MSAs Included in the CCJR Model (continued)

MSA	MSA Name
35620	New York-Newark-Jersey City, NY-NJ-PA.
35980	Norwich-New London, CT.
36260	Ogden-Clearfield, UT.
36420	Oklahoma City, OK.
36740	Orlando-Kissimmee-Sanford, FL.
37860	Pensacola-Ferry Pass-Brent, FL.
38300	Pittsburgh, PA.
38940	Port St. Lucie, FL.
38900	Portland-Vancouver-Hillsboro, OR-WA.
39340	Provo-Orem, UT.
39740	Reading, PA.
40060	Richmond, VA.
40420	Rockford, IL.
40980	Saginaw, MI.
41860	San Francisco-Oakland-Hayward, CA.
42660	Seattle-Tacoma-Bellevue, WA.
42680	Sebastian-Vero Beach, FL.
43780	South Bend-Mishawaka, IN-MI.
41180	St. Louis, MO-IL.
44420	Staunton-Waynesboro, VA.
45300	Tampa-St. Petersburg-Clearwater, FL.
45780	Toledo, OH.
45820	Topeka, KS.
46220	Tuscaloosa, AL.
46340	Tyler, TX.
47260	Virginia Beach-Norfolk-Newport News, VA-NC.
48620	Wichita, KS.

Appendix 2a: Anchor MS-DRGs for CCJR Episodes

The following MS DRGs can initiate CCJR episodes on or after Jan. 1, 2016.

MS-DRG	Descriptor
469	Major joint replacement or reattachment of lower extremity with MCC
470	Major joint replacement or reattachment of lower extremity without MCC

Appendix 2b: Primary ICD-9 Code Ranges for Excluded Part B Services in CCJR as of Jan. 1, 2016.

ICD-9 Code	Description
001	Cholera
002	Typhoid fever
003	Salmonella infections
004	Shigellosis
005	Other bacterial food poisoning
006	Amebiasis
007	Other protozoal intestinal diseases
008	Intestinal infections d/t other organisms
009	Ill-defined intestinal infections
010	Primary tuberculosis infection
011	Pulmonary tuberculosis
012	Other respiratory tuberculosis
013	Tuberculosis of meninges and central nervous
014	Tuberculosis of intestines, peritoneum and mesenteric glands
015	Tuberculosis of bone and joints
016	Tuberculosis of genitourinary system
017	Tuberculosis of other organs
018	Military tuberculosis
020	Plague
021	Tularemia
022	Anthrax
023	Brucellosis
024	Glanders
025	Meliodosis
026	Rat-bite fever
027	Other zoonotic bacterial diseases
045	Acute poliomyelitis
046	Other slow virus infections and prion diseases of CNS
047	Meningitis d/t enterovirus
048	Other enterovirus diseases of central nervous system
049	Other non-arthropod-borne viral diseases of CNS
050	Smallpox
051	Cowpox and paravaccinia
052	Chickenpox
053	Herpes zoster
054	Herpes simplex
055	Measles
056	Rubella
057	Other viral exanthemata

058	Other human herpesvirus
059	Other poxvirus infections
060	Yellow fever
061	Dengue
062	Mosquito-borne viral encephalitis
063	Tick-borne viral encephalitis
064	Viral encephalitis transmitted by other and unspecified arthropods
065	Arthopod-borne hemorrhagic fever
066	Other arthropod-borne viral diseases
070	Viral hepatitis
071	Rabies
072	Mumps
073	Ornithosis
074	Specific diseases d/t Coxsackie virus
075	Infectious mononucleosis
076	Trachoma
077	Other disease of conjunctiva d/t viruses and Chlamydiae
078	Other disease d/t viruses and Chlamydiae
079	Viral and chlamydial infection in conditions classified elsewhere and of unspecified site
080	Louse-borne typhus
081	Other typhus
082	Tick-borne rickettsioses
083	Other rickettsioses
084	Malaria
085	Leishmaniasis
086	Trypanosomiasis
087	Relapsing fever
088	Other arthopod-borne diseases
090	Congenital syphilis
091	Early syphilis, symptomatic
092	Early syphilis, latent
093	Cardiovascular syphilis
094	Neurosyphilis
095	Other forms of late syphilis with symptoms
096	Late syphilis, latent
097	Other and unspecified syphilis
098	Gonococcal infections
099	Other veneral diseases
100	Leptospirosis
101	Vincent's angina
102	Yaws
103	Pinta

104	Other spirochetal infections
110	Dermatophytosis
111	Dermatomycosis, other and unspecified
112	Candidiasis
114	Coccidiodomycosis
115	Histoplasmosis
116	Blastomycotic infection
117	Other mycoses
118	Opportunisitc mycoses
120	Schistosomiasis
121	Other trematode infections
122	Echinococcosis
123	Other cescode infection
124	Trichinosis
125	Filarial infection and dracontiasis
126	Ancylostomiasis and necatoriasis
127	Other intestinal helminthiases
128	Other and unspecified helminthiases
129	Intestinal parasitism, unspecified
130	Toxoplasmosis
131	Trichomoniasis
132	Pediculosis and phthirus
133	Acariasis
134	Other infestation
135	Sarcoidosis
136	Other and unspecified infectious and parasitic diseases
137	Late effects of tuberculosis
138	Late effects of poliomyelitis
139	Late effects of other infectious and parasitic diseases
140-239	Neoplasm diagnoses
320	Bacterial meningitis
321	Meningitis d/t other organisms
322	Meningitis of unspecified cause
323	Encephalitis, myelitis, and encephalomyelitis
324	Intracranial and intraspinal abscess
325	Phlebitis and thrombophlebitis of intracranial venous sinuses
326	Late effects of intracranial abscess or pyogenic infection
327	Organic sleep disorders
360-379	Disorders of the eye and adnexa
380-389	Disorders of the ear and mastoid process
470	Deviated nasal septum
471	Nasal polyps

472	Chronic pharyngitis and nasophayngitis
473	Chronis sinusitis
474	Chronic disease of tonsils and adenoids
475	Peritonsillar abscess
476	Chronic laryngitis and laryngotracheitis
477	Allergic rhinitis
478	Other disease of upper respiratory tract
520-529	Diseases of oral cavity, salivary glands and jaws
540-543	Appendicitis
600-608	Disease of the male genital organs
610-612	Disorders of the breast
614-616	Inflammatory disease of the female pelvic organs
617-629	Other disorders of the female genital tract
630-679	Complications of pregnancy, childbirth and the puerperium
760-779	Certain conditions originating in the perinatal period
800-804	Fracture of skull
805-809	Fracture of neck and trunk
850-854	Intracranial injury, excluding those with skull fracture
940-949	Burns
V20-V29	Person encountering health services in circumstances r/t reproduction and development
V30-V39	Liveborn infants according to type of birth
V88	Acquired absence of other organs and tissue
V89	Other suspected conditions not found
V91	Multiple gestation placenta status

Appendix 2c: MS-DRGs for Excluded Readmissions in CCJR after Jan. 1, 2016

MS-DRG List	Description
001	Heart transplant or implant of heart assist system w/MCC
002	Heart transplant or implant of heart assist system w/o MCC
005	Liver transplant w/ MCC or intestinal transplant
006	Liver transplant w/o MCC
007	Lung transplant
008	Simultaneous pancreas/kidney transplant
009	Old code
010	Pancreas transplant
011	Tracheostomy for face, mouth & neck diagnoses w/MCC
012	Tracheostomy for face, mouth & neck diagnoses w/ CC
013	Tracheostomy for face, mouth & neck diagnoses w/o CC/MCC
014	Allogeneic bone marrow transplant
015	Old code
016	Autologous bone marrow transplant w/ CC/MCC
017	Autologous bone marrow transplant w/o CC/MCC
020	Intracranial vascular procedures w/ Pdx hemorrhage w/MCC
021	Intracranial vascular procedures w/ Pdx hemorrhage w/CC
022	Intracranial Vascular Procedures W Pdx Hemorrhage w/o MCC
023	Cranio w/ major dev impl/acute complex CNS Pdx w/ MCC or chemo implant
024	Cranio w/ major dev impl/acute complex CNS Pdx w/o MCC
025	Craniotomy & endovascular intracranial procedures w/ MCC
026	Craniotomy & endovascular intracranial procedures w/ CC
027	Craniotomy & endovascular intracranial procedures w/o CC/MCC
028	Spinal procedures w/ MCC
029	Spinal procedures w/ CC or spinal neurostimulators
030	Spinal procedures w/o CC/MCC
031	Ventricular shunt procedures w/ MCC
032	Ventricular shunt procedures w/ CC
033	Ventricular shunt procedures w/o CC/MCC
037	Extracranial procedures w/ MCC
038	Extracranial procedures w/ CC
039	Extracranial procedures w/o CC/MCC
040	Periph/cranial nerve & other nerv syst proc w/ MCC
041	Periph/cranial nerve & other nerv syst proc w/ CC or periph neurostim
042	Periph/cranial nerve & other nerv syst proc w/o CC/MCC
052	Spinal disorders & injuries w/ CC/MCC
053	Spinal disorders & injuries w/o CC/MCC
054	Nervous system neoplasms w/ MCC
055	Nervous system neoplasms w/o MCC

082	Traumatic stupor & coma, coma >1 hr w MCC
083	Traumatic stupor & coma, coma >1 Hr w CC
084	Traumatic stupor & coma, coma >1 hr w/o CC/MCC
085	Traumatic stupor & coma, coma <1 hr w MCC
086	Traumatic stupor & coma, coma <1 hr w CC
087	Traumatic stupor & coma, coma <1 hr w/o CC/MCC
088	Concussion w MCC
089	Concussion w CC
090	Concussion w/o CC/MCC
113	Orbital procedures w CC/MCC
114	Orbital procedures w/o CC/MCC
115	Extraocular procedures except orbit
116	Intraocular procedures w CC/MCC
117	Intraocular procedures w/o CC/MCC
129	Major head & neck procedures w CC/MCC or major device
130	Major head & neck procedures w/o CC/MCC
131	Cranial/facial procedures w CC/MCC
132	Cranial/facial procedures w/o CC/MCC
133	Other ear, nose, mouth & throat O.R. procedures w CC/MCC
134	Other ear, nose, mouth & throat O.R. procedures w/o CC/MCC
135	Sinus & mastoid procedures w CC/MCC
136	Sinus & mastoid procedures w/o CC/MCC
137	Mouth procedures w CC/MCC
138	Mouth procedures w/o CC/MCC
139	Salivary gland procedures
146	Ear, nose, mouth & throat malignancy w MCC
147	Ear, nose, mouth & throat malignancy w CC
148	Ear, nose, mouth & throat malignancy w/o CC/MCC
163	Major chest procedures w MCC
164	Major chest procedures w CC
165	Major chest procedures w/o CC/MCC
180	Respiratory neoplasms w MCC
181	Respiratory neoplasms w CC
182	Respiratory neoplasms w/o CC/MCC
183	Major chest trauma w MCC
184	Major chest trauma w CC
185	Major chest trauma w/o CC/MCC
216	Cardiac valve & oth maj cardiothoracic proc w card cath w MCC
217	Cardiac valve & oth maj cardiothoracic proc w card cath w CC
218	Cardiac valve & oth maj cardiothoracic proc w card cath w/o CC/MCC
219	Cardiac valve & oth maj cardiothoracic proc w/o card cath w MCC
220	Cardiac valve & oth maj cardiothoracic proc w/o card cath w CC

221	Cardiac valve & oth maj cardiothoracic proc w/o card cath w/o CC/MCC
222	Cardiac defib implant w cardiac cath w AMI/HF/shock w MCC
223	Cardiac defib implant w cardiac cath w AMI/HF/shock w/o MCC
224	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w MCC
225	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w/o MCC
226	Cardiac defibrillator implant w/o cardiac cath w MCC
227	Cardiac defibrillator implant w/o cardiac cath w/o MCC
228	Other cardiothoracic procedures w MCC
229	Other cardiothoracic procedures w CC
230	Other cardiothoracic procedures w/o CC/MCC
237	Major cardiovasc procedures w MCC
238	Major cardiovasc procedures w/o MCC
242	Permanent cardiac pacemaker implant w MCC
243	Permanent cardiac pacemaker implant w CC
244	Permanent cardiac pacemaker implant w/o CC/MCC
245	AICD generator procedures
258	Cardiac pacemaker device replacement w MC
259	Cardiac pacemaker device replacement w/o MCC
260	Cardiac pacemaker revision except device replacement w MCC
261	Cardiac pacemaker revision except device replacement w CC
262	Cardiac pacemaker revision except device replacement w/o CC/MCC
263	Vein ligation & stripping
264	Other circulatory system O.R. procedures
265	AICD lead procedures
266	Old code
267	Old code
268	Aortic and heart assist procedures except pulsation balloon w MCC
269	Aortic and heart assist procedures except pulsation balloon w/o MCC
270	Other major cardiovascular procedures w MCC
271	Other major cardiovascular procedures w CC
272	Other major cardiovascular procedures w/o CC MCC
326	Stomach, esophageal & duodenal proc w MCC
327	Stomach, esophageal & duodenal proc w CC
328	Stomach, esophageal & duodenal proc w/o CC/MCC
329	Major small & large bowel procedures w MCC
330	Major small & large bowel procedures w CC
331	Major small & large bowel procedures w/o CC/MCC
332	Rectal resection w MCC
333	Rectal resection w CC
334	Rectal resection w/o CC/MCC
335	Peritoneal adhesiolysis w MCC
336	Peritoneal adhesiolysis w CC

337	Peritoneal adhesiolysis w/o CC/MCC
338	Appendectomy w complicated principal diag w MCC
339	Appendectomy w complicated principal diag w CC
340	Appendectomy w complicated principal diag w/o CC/MCC
341	Appendectomy w/o complicated principal diag w MCC
342	Appendectomy w/o complicated principal diag w CC
343	Appendectomy w/o complicated principal diag w/o CC/MCC
344	Minor small & large bowel procedures w MCC
345	Minor small & large bowel procedures w CC
346	Minor small & large bowel procedures w/o CC/MCC
347	Anal & stomal procedures w MCC
348	Anal & stomal procedures w CC
349	Anal & stomal procedures w/o CC/MCC
350	Inguinal & femoral hernia procedures w MCC
351	Inguinal & femoral hernia procedures w CC
352	Inguinal & femoral hernia procedures w/o CC/MCC
353	Hernia procedures except inguinal & femoral w MCC
354	Hernia procedures except inguinal & femoral w CC
355	Hernia procedures except inguinal & femoral w/o CC/MCC
374	Digestive malignancy w MCC
375	Digestive malignancy w CC
376	Digestive malignancy w/o CC/MCC
405	Pancreas, liver & shunt procedures w MCC
406	Pancreas, liver & shunt procedures w CC
407	Pancreas, liver & shunt procedures w/o CC/MCC
408	Biliary tract proc except only cholecyst w or w/o C.D.E. w MCC
409	Biliary tract proc except only cholecyst w or w/o C.D.E. w CC
410	Biliary tract proc except only cholecyst w or w/o C.D.E. w/o CC/MCC
411	Cholecystectomy w C.D.E. w MCC
412	Cholecystectomy w C.D.E. w CC
413	Cholecystectomy w C.D.E. w/o CC/MCC
414	Cholecystectomy except by laparoscope w/o C.D.E. w MCC
415	Cholecystectomy except by laparoscope w/o C.D.E. w CC
416	Cholecystectomy except by laparoscope w/o C.D.E. w/o CC/MCC
417	Laparoscopic cholecystectomy w/o C.D.E. w MCC
418	Laparoscopic cholecystectomy w/o C.D.E. w CC
419	Laparoscopic cholecystectomy w/o C.D.E. w/o CC/MCC
420	Hepatobiliary diagnostic procedures w MCC
421	Hepatobiliary diagnostic procedures w CC
422	Hepatobiliary diagnostic procedures w/o CC/MC
423	Other hepatobiliary or pancreas O.R. procedures w MCC
424	Other hepatobiliary or pancreas O.R. procedures w CC

425	Other hepatobiliary or pancreas O.R. procedures w/o CC/MCC
435	Malignancy Of hepatobiliary system or pancreas w MCC
436	Malignancy of hepatobiliary system or pancreas w CC
437	Malignancy of hepatobiliary system or pancreas w/o CC/MCC
453	Combined anterior/posterior spinal fusion w MCC
454	Combined anterior/posterior spinal fusion w CC
455	Combined anterior/posterior spinal fusion w/o CC/MCC
456	Spinal fus exc cerv w spinal curv/malig/infec or 9+ fus w MCC
457	Spinal fus exc cerv w spinal curv/malig/infec or 9+ fus w CC
458	Spinal fus exc cerv w spinal curv/malig/infec or 9+ fus w/o CC/MCC
459	Spinal fusion except cervical w MCC
460	Spinal fusion except cervical w/o MCC
469	Major joint replacement or reattachment of lower extremity w MCC
470	Major joint replacement or reattachment of lower extremity w/o MCC
471	Cervical spinal fusion w MCC
472	Cervical spinal fusion w CC
473	Cervical spinal fusion w/o CC/MCC
506	Major thumb or joint procedures
507	Major shoulder or elbow joint procedures w CC/MCC
508	Major shoulder or elbow joint procedures w/o CC/MCC
510	Shoulder, elbow, or forearm proc, exc major joint proc w MCC
511	Shoulder, elbow, or forearm proc, exc major joint proc w CC
512	Shoulder, elbow or forearm proc, exc major joint proc w/o CC/MCC
513	Hand or wrist proc, except major thumb or joint proc w CC/MCC
514	Hand or wrist proc, except major thumb or joint proc w/o CC/MCC
518	Old code
519	Old code
520	Old code
542	Pathological fractures & musculoskelet & conn tiss malig w MCC
543	Pathological fractures & musculoskelet & conn tiss malig w CC
544	Pathological fractures & musculoskelet & conn tiss malig w/o CC/MCC
582	Mastectomy for malignancy w CC/MCC
583	Mastectomy for malignancy w/o CC/MCC
584	Breast biopsy, local excision & other breast procedures w CC/MCC
585	Breast biopsy, local excision & other breast procedures w/o CC/MCC
597	Malignant breast disorders w MCC
598	Malignant Breast Disorders w CC
599	Malignant Breast Disorders w/o CC/MCC
604	Trauma to the skin, subcut tiss & breast w MCC
605	Trauma to the skin, subcut tiss & breast w/o MCC
614	Adrenal & pituitary procedures w CC/MCC
615	Adrenal & pituitary procedures w/o CC/MCC

619	O.R. procedures for obesity w MCC
620	O.R. procedures for obesity w CC
621	O.R. procedures for obesity w/o CC/MCC
625	Thyroid, parathyroid & thyroglossal procedures w MCC
626	Thyroid, parathyroid & thyroglossal procedures w CC
627	Thyroid, parathyroid & thyroglossal procedures w/o CC/MCC
652	Kidney transplant
653	Major bladder procedures w MCC
654	Major Bladder Procedures w CC
655	Major bladder procedures w/o CC/MCC
656	Kidney & ureter procedures for neoplasm w MCC
657	Kidney & ureter procedures for neoplasm w CC
658	Kidney & ureter procedures for neoplasm w/o CC/MCC
659	Kidney & ureter procedures for non-neoplasm w MCC
660	Kidney & ureter procedures for non-neoplasm w CC
661	Kidney & ureter procedures for non-neoplasm w/o CC/MCC
662	Minor bladder procedures w MCC
663	Minor bladder procedures w CC
664	Minor bladder procedures w/o CC/MCC
665	Prostatectomy w MCC
666	Prostatectomy w CC
667	Prostatectomy w/o CC/MCC
668	Transurethral procedures w MCC
669	Transurethral procedures w CC
670	Transurethral procedures w/o CC/MCC
671	Urethral procedures w CC/MCC
672	Urethral procedures w/o CC/MCC
686	Kidney & urinary tract neoplasms w MCC
687	Kidney & urinary tract neoplasms w CC
688	Kidney & urinary tract neoplasms w/o CCC/MCC
707	Major male pelvic procedures w CC/MCC
708	Major male pelvic procedures w/o CC/MCC
709	Penis procedures w CC/MCC
710	Penis procedures w/o CC/MCC
711	Testes procedures w CC/MCC
712	Testes procedures w/o CC/MCC
713	Transurethral prostatectomy w CC/MCC
714	Transurethral prostatectomy w/o CC/MCC
715	Other male reproductive system O.R. proc for malignancy w CC/MCC
716	Other male reproductive system O.R. proc for malignancy w/o CC/MCC
717	Other male reproductive system O.R. proc exc malignancy w CC/MCC
718	Other male reproductive system O.R. proc exc malignancy w/o CC/MCC

722	Malignancy, male reproductive system w MCC
723	Malignancy, male reproductive system w CC
724	Malignancy, male reproductive system w/o CC/MCC
734	Pelvic evisceration, rad hysterectomy & rad vulvectomy w CC/MCC
735	Pelvic evisceration, rad hysterectomy & rad vulvectomy w/o CC/MCC
736	Uterine & adnexa proc for ovarian or adnexal malignancy w MCC
737	Uterine & adnexa proc for ovarian or adnexal malignancy w CC
738	Uterine & adnexa proc for ovarian or adnexal malignancy w/o CC/MCC
739	Uterine, adnexa proc for non-ovarian/adnexal malig w/o MCC
740	Uterine, adnexa proc for non-ovarian/adnexal malig w CC
741	Uterine, adnexa proc for non-ovarian/adnexal malig w/o CC/MCC
742	Uterine & adnexa proc for non-malignancy w CC/MCC
743	Uterine & adnexa proc for non-malignancy w/o CC/MCC
744	D&C, conization, laparoscopy & tubal interruption w CC/MCC
745	D&C, conization, laparoscopy & tubal interruption w/o CC/MCC
746	Vagina, cervix & vulva procedures w CC/MCC
747	Vagina, cervix & vulva procedures w/o CC/MCC
748	Female reproductive system reconstructive procedures
749	Other female reproductive system O.R. procedures w CC/MCC
750	Other female reproductive system O.R. procedures w/o CC/MCC
754	Malignancy, female reproductive system w MCC
755	Malignancy, female reproductive system W CC
756	Malignancy, female reproductive system w/o CC/MCC
765	Cesarean section w CC/MCC
766	Cesarean Section w/o CC/MCC
767	Vaginal delivery w sterilization &/or D&C
768	Vaginal delivery w O.R. proc except steril &/or D&C
769	Postpartum & post abortion diagnoses w O.R. procedure
770	Abortion w D&C, aspiration curettage or hysterotomy
799	Splenectomy w MCC
800	Splenectomy w CC
801	Splenectomy w/o CC/MCC
814	Reticuloendothelial & immunity disorders w MCC
815	Reticuloendothelial & immunity disorders w CC
816	Reticuloendothelial & immunity disorders w/o CC/MCC
820	Lymphoma & leukemia w major O.R. procedure w MCC
821	Lymphoma & leukemia w major O.R. procedure w CC
822	Lymphoma & leukemia w major O.R. procedure w/ CC/MCC
823	Lymphoma & non-acute leukemia w other O.R. proc w MCC
824	Lymphoma & non-acute leukemia w other O.R. proc w CC
825	Lymphoma & non-acute leukemia w other O.R. proc w/o CC/MCC
826	Myeloprolif disord or poorly diff neopl w maj O.R. proc w MCC

827	Myeloprolif disord or poorly diff neopl w Maj O.R. proc w CC
828	Myeloprolif disord or poorly diff neopl w maj O.R. proc w/o CC/MCC
829	Myeloprolif disord or poorly diff neopl w other O.R. proc w CC/MCC
830	Myeloprolif disord or poorly diff neopl w other O.R. proc w/o CC/MCC
834	Acute leukemia w/o major O.R. procedure w MCC
835	Acute leukemia w/o major O.R. procedure w CC
836	Acute leukemia w/o major O.R. procedure w/o CC/MCC
837	Chemo w acute leukemia as sdx or w high dose chemo agent w MCC
838	Chemo w acute leukemia as sdx w CC or high dose chemo agent
839	Chemo w acute leukemia as sdx w/o CC/MCC
840	Lymphoma & non-acute leukemia w MCC
841	Lymphoma & non-acute leukemia w CC
842	Lymphoma & non-acute leukemia w/o CC/MCC
843	Other myeloprolif dis or poorly diff neopl diag w MCC
844	Other myeloprolif dis or poorly diff neopl diag w CC
845	Other myeloprolif dis or poorly diff neopl diag w/o CC/MCC
846	Chemotherapy w/o acute leukemia as secondary diagnosis w MCC
847	Chemotherapy w/o acute leukemia as secondary diagnosis w CC
848	Chemotherapy w/o acute leukemia as secondary diagnosis w/o CC/MCC
849	Radiotherapy
876	O.R. procedure w principal diagnoses of mental illness
906	Hand procedures for injuries
913	Traumatic injury w MCC
914	Traumatic injury w/o MCC
927	Extensive burns or full thickness burns w mv 96+ hrs w skin graft
928	Full thickness burn w skin graft or inhal inj w CC/MCC
929	Full thickness burn w skin graft or inhal inj w/o CC/MCC
933	Extensive burns or full thickness burns w mv 96+ hrs w/o skin graft
934	Full thickness burn w/o skin grft or inhal inj
935	Non-extensive burns
955	Craniotomy for multiple significant trauma
956	Limb reattachment, hip & femur proc for multiple significant trauma
957	Other O.R. procedures for multiple significant trauma w MCC
958	Other O.R. procedures for multiple significant trauma w CC
959	Other O.R. procedures for multiple significant trauma w/o CC/MCC
963	Other multiple significant trauma w MCC
964	Other multiple significant trauma w CC
965	Other multiple significant trauma w/o CC/MCC
969	HIV w extensive O.R. procedure w MCC
970	HIV w extensive O.R. procedure w/o MCC
984	Prostatic O.R. procedure unrelated to principal diagnosis w MCC
985	Prostatic O.R. procedure unrelated to principal diagnosis w CC

986	Prostatic O.R. procedure unrelated to principal diagnosis w/o CC/MCC

Appendix 2d: Additional Exclusions Effective Jan. 1, 2016

Hemophilia clotting factors, identified through HCPCS code, diagnosis code, and revenue center code on IPPS inpatient hospital claims
New Technology Add-On Payments, identified through value code 77 on IPPS inpatient hospital claims

Appendix 3 - Models with Potential Overlap with CCJR

TABLE 15—CURRENT PROGRAMS AND MODELS WITH POTENTIAL OVERLAP WITH PROPOSED CCJR MODEL

Program/model	Brief description	Shared savings?	Per-beneficiary-per-month (PBPM) payments?
Pioneer	ACO shared savings program	Yes	No.
Medicare Shared Savings Program (MSSP)	ACO shared savings program	Yes	No.
Next Generation ACO	ACO shared savings program	Yes	No.
Comprehensive Primary Care initiative (CPCi)	Pays primary care providers for improved and comprehensive care management.	Yes	Yes.
Multi-payer Advanced Primary Care Practice (MAPCP)	Multi-payer model for advanced primary care practices, or "medical homes".	Yes	Yes.
Bundled Payments for Care Improvement (BPCI)	Bundled payment program for acute or post-acute services or both.	No	No.
Oncology Care Model (OCM)	Multi-payer model for oncology physician group practices.	No	Yes.
Comprehensive ESRD Care Initiative (CEC)	ACO for ESRD Medicare beneficiaries	Yes	No.
Million Hearts	Model targeting prevention of heart attack and stroke	No	Yes.
Medicare Care Choices Model	Hospice concurrent care model	No	Yes.

Appendix 4 – Performance Periods for Preoperative and Postoperative THA/TKA Voluntary Data

TABLE 16—EXAMPLE OF POTENTIAL PERFORMANCE PERIODS FOR PRE- AND POST-OPERATIVE THA/TKA VOLUNTARY DATA SUBMISSION

CCJR model year	Performance period	Patient population eligible for THA/TKA voluntary data submission	Requirements for successful THA/TKA voluntary data submission *
2016	April 1, 2016 through June 30, 2016.	All patients undergoing elective primary THA/TKA procedures performed between April 1, 2016 and June 30, 2016.	Submit PRE-operative data on primary elective THA/TKA procedures for ≥80% of procedures performed between April 1, 2016 and June 30, 2016.
2017	April 1, 2016 through June 30, 2016.	All patients undergoing elective primary THA/TKA procedures performed between April 1, 2016 and June 30, 2016.	Submit POST-operative data on primary elective THA/TKA procedures for ≥80% of procedures performed between April 1, 2016 and June 30, 2016.
2017	July 1, 2016 through June 30, 2017.	All patients undergoing elective primary THA/TKA procedures performed between July 1, 2016 and June 30, 2017.	Submit PRE-operative data on primary elective THA/TKA procedures for ≥80% of procedures performed between July 1, 2016 and June 30, 2017.
2018	July 1, 2016 through June 30, 2017.	All patients undergoing elective primary THA/TKA procedures performed between July 1, 2016 and June 30, 2017.	Submit POST-operative data on primary elective THA/TKA procedures for ≥80% of procedures performed between July 1, 2016 and June 30, 2017.
2018	July 1, 2017 through June 30, 2018.	All patients undergoing elective primary THA/TKA procedures performed between July 1, 2017 and June 30, 2018.	Submit PRE-operative data on primary elective THA/TKA procedures for ≥80% of procedures performed between July 1, 2017 and June 30, 2018.
2019	July 1, 2017 through June 30, 2018.	All patients undergoing elective primary THA/TKA procedures performed between July 1, 2017 and June 30, 2018.	Submit POST-operative data on primary elective THA/TKA procedures for ≥80% of procedures performed between July 1, 2017 and June 30, 2018.
2019	July 1, 2018 through June 30, 2019.	All patients undergoing elective primary THA/TKA procedures performed between July 1, 2018 and June 30, 2019.	Submit PRE-operative data on primary elective THA/TKA procedures for ≥80% of procedures performed between July 1, 2018 and June 30, 2019.
2020	July 1, 2018 through June 30, 2019.	All patients undergoing elective primary THA/TKA procedures performed between July 1, 2018 and June 30, 2019.	Submit POST-operative data on primary elective THA/TKA procedures for ≥80% of procedures performed between July 1, 2018 and June 30, 2019.
2020	July 1, 2019 through June 30, 2020.	All patients undergoing elective primary THA/TKA procedures performed between July 1, 2019 and June 30, 2020.	Submit PRE-operative data on primary elective THA/TKA procedures for ≥80% of procedures performed between July 1, 2019 and June 30, 2020.
2016	3 months	All patients undergoing elective primary THA/TKA procedures performed between April 1, 2016 and June 30, 2016.	Submit PRE-operative data on primary elective THA/TKA procedures for ≥80% of procedures performed between April 1, 2016 and June 30, 2016.
2017	15 months	All patients undergoing elective primary THA/TKA procedures performed between April 1, 2016 and June 30, 2017.	1. Submit POST-operative data on primary elective THA/TKA procedures for ≥80% of procedures performed between April 1, 2016 and June 30, 2016. 2. Submit PRE-operative data on primary elective THA/TKA procedures for ≥80% of procedures performed between July 1, 2016 and June 30, 2017.
2018	24 months	All patients undergoing elective primary THA/TKA procedures performed between July 1, 2016 and June 30, 2018.	1. Submit POST-operative data on primary elective THA/TKA procedures for ≥80% of procedures performed between July 1, 2016 and June 30, 2017.

Appendix 4 – Performance Periods for Preoperative and Postoperative THA/TKA Voluntary Data (Continued)

TABLE 16—EXAMPLE OF POTENTIAL PERFORMANCE PERIODS FOR PRE- AND POST-OPERATIVE THA/TKA VOLUNTARY DATA SUBMISSION—Continued

CCJR model year	Performance period	Patient population eligible for THA/TKA voluntary data submission	Requirements for successful THA/TKA voluntary data submission *
			2. Submit PRE-operative data on primary elective THA/TKA procedures for ≥80% of procedures performed between July 1, 2017 and June 30, 2018.
2019	24 months	All patients undergoing elective primary THA/TKA procedures performed between July 1, 2017 and June 30, 2019.	1. Submit POST-operative data on primary elective THA/TKA procedures for ≥80% of procedures performed between July 1, 2017 and June 30, 2018. 2. Submit PRE-operative data on primary elective THA/TKA procedures for ≥80% of procedures performed between July 1, 2018 and June 30, 2019.
2020	24 months	All patients undergoing elective primary THA/TKA procedures performed between July 1, 2018 and June 30, 2020.	1. Submit POST-operative data on primary elective THA/TKA procedures for ≥80% of procedures performed between July 1, 2018 and June 30, 2019. 2. Submit PRE-operative data on primary elective THA/TKA procedures for ≥80% of procedures performed between July 1, 2019 and June 30, 2020.

* Requirements for determining successful submission of THA/TKA voluntary data are located in section III.D.3.a.(9) of this proposed rule.

Appendix 5 – CCRJ Gainsharing & Alignments Payment Conditions and Restrictions

- No entity or individual, whether or not a party to a Participation Agreement, may receive gainsharing payments in CCJR on the volume or value of past or anticipated referrals or other business generated to, from, or among a participant hospital, any CCJR collaborators, and any individual or entity affiliated with a participant hospital or CCJR collaborator.
- Participant hospitals would not be required to share reconciliation payments, internal cost savings, or responsibility for repayment to CMS with other providers and suppliers, but if they elect to do so, such activities would be limited to the provisions prescribed in the proposed rule.
- Gainsharing payments must be distributed on an annual basis, and would be required to meet certain criteria.
- Alignment payments from a CCJR collaborator to a participant hospital may be made at any interval, and are required to meet the certain criteria.
- Each CCJR Sharing Arrangement must stipulate that any CCJR collaborator that is subject to any action involving noncompliance with the provisions of the proposed rule, engaged in fraud or abuse, providing substandard care, or have other integrity problems be ineligible to receive any gainsharing payments.
- The aggregate amount of the total gainsharing payments distributed by the participant hospital derived from a CCJR reconciliation payment may not exceed the amount of the reconciliation payment.
- The aggregate amount of the total alignment payments received by the participant hospital may not exceed 50 percent of the participant hospital's repayment amount due to CMS.
- The participant hospital must retain at least 50 percent of its responsibility for repayment to CMS pursuant to the repayment amount reflected in each annual reconciliation report, under the CCJR model.
- A CCJR Sharing Arrangement must limit the amount a single CCJR collaborator may make in Alignment Payments to a single participant hospital. CMS proposes that a single CCJR collaborator not make an Alignment Payment to a participant hospital that represents an amount greater than 25 percent of the repayment amount reflected on the participant hospital's annual reconciliation report.
- Gainsharing and Alignment Payments must not induce the participant hospital, CCJR collaborators, or the employees, contractors, or designees of the participant hospital or CCJR collaborators to reduce or limit medically necessary services to any Medicare beneficiary.
- Individual physician and nonphysician practitioners, whether or not a party to a CCJR Sharing Arrangement, must retain their ability to make decisions in the best interests of the patient.
- Entities furnishing services to beneficiaries during a CCJR episode, whether or not a party to a CCJR sharing arrangement, must retain their ability to make decisions in the best interests of the patient, including the selection of devices, supplies, and treatments.
- Gainsharing methodologies for calculating gainsharing and alignment payments must not directly account for volume or value of referrals, or business otherwise generated, between or among a participant hospital, any CCJR collaborators, and any individual or entity affiliated with a participant hospital or CCJR collaborator.
- Gainsharing payments must be derived solely from reconciliation payments or internal cost savings or both.
- The total amount of gainsharing payments for a calendar year paid to an individual physician or nonphysician practitioner who is a CCJR collaborator must not exceed a cap.
- The total amount of gainsharing payments for a calendar year paid to a physician group practice that is a CCJR collaborator must not exceed a cap.