Executive Summary – Comprehensive Care for Joint Replacement Final Rule

Top 10 Issues Providers Need to Understand from the Comprehensive Care for Joint Replacement (CJR) Final Rule:

The CJR final rule was published in the Nov. 24, 2015 Federal Register. CMS finalized its new payment model that will bundle payment to acute care hospitals for hip and knee replacement surgery. CMS delayed the start of the CJR until April 1, 2016; the program will still conclude Dec. 31, 2020. Hospitals in which the joint replacement takes place will be held accountable for the quality and costs of the entire episode of care from the time of the surgery through 90 days after discharge. A full summary of the rule will be available shortly.

1) *Episode of Care*: An episode begins with a Medicare Part A beneficiary's admission for a procedure that results in the assignment of MS-DRG 469 – 470. The patient must be admitted to an IPPS hospital (that is not participating in the Bundled Payments for Care Improvement [BPCI] initiative) located in one of the selected metropolitan statistical areas (MSAs). The episode includes all Part A and Part B expenditures that occur within 90 days of discharge. A limited number of services CMS considers unrelated are excluded.

2) *Model Duration*: The model begins on April 1, 2016 and will end on Dec. 31, 2020.

3) *Selected MSAs*: The final rule selected 67 MSAs for participation. (See Appendix 1 for a list of selected areas.) Eight MSAs were removed from the final rule due to high rates of qualifying episodes being assignment to a BPCI participant.

4) *Payment Method*: All providers involved in an episode of care will continue to be paid under the relevant fee-for-service payment schedule. Expenditures for an episode will be compared to a target price.

5) *Target Price*: CMS will use three years of historical blended hospital-specific and regional payment data grouped into episodes of care. The blended target price increasingly will be based on regional data. The set of years used will be refreshed every other year.

Target Price Data Blend: Regional vs. Hospital Specific

Performance Year(s)	% Regional	% Hospital Specific
1 – 2	33.33	66.66
3	66.66	33.33
4 – 5	100	0

The historical data will be updated to reflect current pricing in the various Medicare FFS payment systems involved. Certain special payment provisions designed to improve value will be excluded from both the target price and actual spending calculation. Once CMS calculates a target price it will be reduced by up to 2 percent in years two and three and 3 percent in years four and five based on how a facility scores on a quality composite.

Separate target prices are calculated for MS-DRGs 469 and 470 with and without hip fractures. This is the only form of risk adjustment used in the CJR model.

6) *Degree of Risk Transferred:* In the first year of the program, hospitals have upside opportunity only if their actual episode expenditure is below the target price. Beginning in year two, hospitals must repay CMS if their actual expenditure is above the target price.
The model incorporates a progressive stop-loss and stop-gain mechanism.

Stop-Loss

Facility Type	Year 2	Year 3	Year 4/5
Non-MDH/RRC/SCH	5%	10%	20%
MDH/RRC/SCH	3%	5%	5%

Stop-Gain

Facility Type	Year 2	Year 3	Year 4/5
Non-MDH/RRC/SCH	5%	10%	20%
MDH/RRC/SCH	3%	5%	5%

To protect hospitals against catastrophic cases, episode costs will be capped at two standard deviations above the mean. Any episode that exceeds the ceiling amount will be assigned the ceiling amount instead of the actual episode cost.

7) *Quality Measures*: Hospitals will be evaluated on three quality measures: Complications (NQF #1550: Hospital Level Risk Standardized Complication Rate (RSCR) following primary THA/TKA), HCAHPS (NQF #0166), and a voluntarily submitted measure of patient outcomes following THA/TKA. Hospitals will receive points for the complications measure and HCAHPS based on their performance relative to all hospitals nationally. For the patient-reported outcomes measure, they will receive points for successfully submitting data. The points awarded for each measure will be blended into a composite. Based on how a hospital scores, it will be assigned to one of four categories: below acceptable, acceptable, good, and excellent. Repayment risk will progressively decrease as a hospital moves from below acceptable to excellent.

8) *Gainsharing*: Hospitals can enter into agreements with physicians and post-acute providers in order to align incentives. These agreements can be upside only (gainsharing) or include downside risk (alignment payments) should the actual per-episode cost exceed the target price. Gainsharing agreements with physicians can also include both savings generated for CMS and internal cost savings generated for the hospital through improved efficiency and supply cost management.

9) *Data Sharing*: The final rule greatly improved the accessibility of data for participating hospitals. Hospitals will only need to request the data one time to receive summary regional and hospital-specific data. Claims level data for the hospital will also be available. While CMS did not finalize a frequency, the final rule states that data will be available at least on a quarterly basis. Beneficiaries can no longer opt out of having their data shared.

10) *Waivers*: CMS and the Office of Inspector General issued a joint statement waiving the federal anti-kickback and physician self-referral statutes to facilitate gainsharing arrangements for CJR participants.

    The rule also waives Medicare regulations related to the following:

    - SNF Three-Day Rule: During performance years 2-5 of the program, beneficiaries discharged from an anchor admission of a CJR episode to a SNF with an overall rating of three stars or more will receive coverage for their SNF stay even if they don't have a "qualifying" three-day stay in an acute hospital.
    - Home Health: While the rule does not waive the homebound requirement, it does waive the incident-to rule. CJR beneficiaries may receive a limited number of post-discharge home visits.
    - Telehealth: The geographic site requirements are waived for beneficiaries involved in a CJR episode for visits related to the episode of care.

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Appendix 1: List of Selected Cities

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
17860	Columbia, MO
18580	Corpus Christi, TX
19500	Decatur, IL
19740	Denver-Aurora-Lakewood, CO
20020	Dothan, AL
20500	Durham-Chapel Hill, NC
22420	Flint, MI
22500	Florence, SC
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
30700	Lincoln, NE
31080	Los Angeles-Long Beach-Anaheim, CA
31180	Lubbock, TX
31540	Madison, WI
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

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MSA	MSA Name
34980	Nashville-Davidson—Murfreesboro—Franklin, TN
35300	New Haven-Milford, CT
35380	New Orleans-Metairie, LA
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
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
48620	Wichita, KS