Comprehensive Care for Joint Replacement Payment Model
Final Rule Fact Sheet

Description: This document provides an overview of the final rule to implement a new Comprehensive Care for Joint Replacement (CCJR) payment model for Medicare Part A and B. The final rule with comment period is available in the Nov. 24, 2015, *Federal Register*.

Effective Date: The final rule is effective on Jan. 15, 2016, and applicable on April 1, 2016, when the first model performance period begins.

Table of Contents

Overview

CMS released a final rule that implements 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 will receive retrospective bundled payments for episodes of care for lower extremity joint replacement (LEJR) or reattachment of a lower extremity. Under the model, all related care within 90 days of hospital discharge from the joint replacement procedure will be included in the episode of care. CMS believes that this model will further its goals in improving the efficiency and quality of care for Medicare beneficiaries with 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. CMS will continue paying hospitals and other providers and suppliers according to the usual Medicare fee-for-service (FFS) payment systems during all five performance years. However, after the completion of a performance year, CMS will retrospectively calculate a participant hospital's actual episode spending based on the episode definition.

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. 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 Social Security Act (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. They also allow participants to receive payment, in part, based on the reduction in expenditures for Medicare arising from their care redesign efforts. Unlike the CCJR, the BPCI initiative is voluntary in nature, and under this 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.

The CCJR model is different from BPCI because it will require participation of all hospitals (with limited exceptions) throughout selected geographic areas, which will result in a model that includes varying hospital types. However, the BPCI is relevant because its design informs and supports the CCJR model. CMS is interested in testing and evaluating the impact of an episode payment approach for LEJRs in a variety of other circumstances, including among those hospitals that have not chosen to voluntarily participate because it has not tested bundled payments for these hospitals previously. Most importantly, participation of hospitals in selected

geographic areas will allow CMS to test bundled payments without introducing selection bias, including that which is inherent in the BPCI model due to self-selected participation.

Excluded Hospitals

For purposes of the CCJR model, CMS finalized the term ‘‘hospital’’ to mean a hospital subject to the IPPS as defined in section 1886(d)(1)(B) of the Act. This statutory definition of hospital includes only acute care hospitals paid under the IPPS, thus excluding Maryland hospitals from participating in CCJR, and therefore, excluding payments to Maryland hospitals in the regional pricing calculations described in section III.C.4 of the final rule. Maryland hospitals are paid under rates set by the state, instead of the inpatient prospective payment system (IPPS) or outpatient prospective payment system (OPPS).

Hospitals selected for the model that are active Model 1 BPCI participant hospitals as of July 1, 2015, or episode initiators for LEJR episodes in the riskbearing phase of Model 2 or 4 of BPCI as of Oct. 1, 2015, are excluded from participating in CCJR during the time that their qualifying episodes are included in one of the BPCI models. LEJR episodes initiated by other providers or suppliers under BPCI Model 2 or 3 (where the surgery takes place at the participant hospital) are excluded from CCJR. Otherwise qualifying LEJR episodes (that is, those that are not part of a Model 3 BPCI LEJR episode or a Model 2 physician group practice-initiated LEJR episode) at the participant hospital are included in CCJR. A chart illustrating the inclusion of episodes in CCJR relative to the BPCI can be found in ***Appendix 1*** of this document (pg. 73288 of the final rule).

Episode Initiators

IPPS hospitals, including Medicare-Dependent Hospitals (MDHs), Rural Referral Centers (RRCs), and Sole Community Hospital (SCHs), will be designated as the episode initiators. IPPS hospitals physically located in an area selected for participation in the CCJR model, according to the address associated with the CMS Certification Number (CCN), will be required to participate in the model and bear the financial responsibility for LEJR episodes of care under the CCJR model. For hospitals that share a CCN across various locations, all hospitals under that CCN would be required to participate in the CJR model if the physical address associated with the CCN is in the metropolitan statistical area (MSA), unless otherwise excluded. Similarly, all hospitals under the same CCN, even if some are physically located in the MSA selected for participation, would not participate in the CJR model if the physical address associated with the CCN is not in the MSA.

Episodes will 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 470 (major joint replacement or reattachment of lower extremity without MCC), and end 90 days after the date of discharge from the hospital. The episode will include the LEJR procedure, inpatient stay, and all related care (as defined by CMS) covered under Medicare Parts A and B within the 90 days after discharge, including hospital care, post-acute care (PAC), and physician services.

Hospitals paid under the IPPS and physically located in selected geographic areas will be required to participate in the CCJR model, with limited exceptions. Eligible beneficiaries who receive care at these hospitals will automatically be included in the model. Geographic areas, based on MSAs, were selected for the model through a stratified random sampling methodology based on the following criteria: historical episode wage-adjusted payment quartiles and population size halves.

Also, unlike BPCI, the CCJR rule does not include a role for convening organizations. CMS is open to reconsidering the eligibility of additional entities to be CCJR collaborators in the future based on the early implementation experience with the CCJR model. However at this time, the final rule does not allow additional entities or individuals beyond those listed as CCJR collaborators in the proposed rule to share in risk or potential gains.

Clinical Dimension of Episodes of Care

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. The model performance period ends 90 days after discharge from the acute care hospital in which the anchor hospitalization took place. The episode of care beginning upon admission for the anchor hospitalization is consistent with LEJR episode initiation under Model 2 of BPCI. See section on Included Services, pgs. 73303-73315.

Options for Geographic Area Selection

CMS will include 67 of the originally selected 75 MSAs from its eight selection groups. CMS used updated BPCI participation level information in the application of the MSA exclusion rules for the final rule, resulting in the exclusion of an additional eight MSAs that were previously selected. CMS will post the list of the participant hospitals in the selected MSAs on the CCJR website at *http://innovation.cms.gov/initiatives/CCJR*. This list will be updated throughout the model to account for circumstances such as hospital mergers, BPCI termination, and new hospitals within the selected MSAs. ***Appendix 2*** includes the final list of the MSAS that will be included in the CCJR model (Table 4 of the final rule).

Although MSAs are revised periodically, with additional counties added or removed, CMS will 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 will not add hospitals or remove them from the model if new counties are added or removed from the MSAs after the program has started. These reassigned counties will retain the same CCJR status they had at the beginning of the initiative. CMS retains the possibility of adding a hospital that is opened or incorporated within one of the selected counties after the selection is made and during the period of performance. Hospitals in selected counties that do not have any LEJR cases that qualify for CCJR, due to their participation in the BPCI initiative as a hospital initiator in an LEJR episode, will become subject to CCJR at the time their participation in BPCI ends and their episodes become eligible for CCJR.

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 (ESRD)
- The beneficiary is not enrolled in any managed care plan (for example, Medicare Advantage, Health Care Prepayment Plans, or cost-based HMOs)
- 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

These criteria are also consistent with Model 2 of BPCI, as well as most other Innovation Center models that do not target a specific subpopulation of beneficiaries. CMS will not include beneficiaries enrolled in Medicare Advantage plans because it is unable to capture or appropriately attribute to the episode the related Medicare payments.

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. Disease-related diagnoses, such as osteoarthritis of the hip or knee, will be included. Body system-related diagnoses will also be included because they relate to complications that may arise from interactions with the healthcare system. CMS is adding the following new definition for the CCJR model: ''Provider of outpatient therapy services,'' which means a provider or supplier furnishing:

1) Outpatient physical therapy services
2) Outpatient occupational therapy
3) Outpatient speech-language pathology services

CMS is also finalizing its proposal, with modification, to remove the term ''independent'' preceding outpatient therapy services. The related items and services included in CCJR episodes, defined by all of the clinical conditions requiring an admission to an IPPS hospital that results in a discharge from MS–DRG 469 or 470 will be the following items and services paid under Medicare Part A or Part B, after the final exclusions are applied:

- Physicians' services
- Inpatient hospital services (including readmissions), with certain exceptions
- Inpatient psychiatric facility services
- Long term care hospital services
- Inpatient rehabilitation facility (IRF) services
- Skilled nursing facility (SNF) services

- Home health agency services
- Hospital outpatient services
- Outpatient therapy services
- Clinical laboratory services
- Durable medical equipment
- Part B drugs
- Hospice

CMS will not include all Part D-covered drugs from the list of related items and services included in CCJR episodes.

Excluded Services
CMS will exclude only those Medicare Part A and B-covered items and services furnished during the episode that are unrelated to LEJR procedures based on clinical justification, and the exclusions will apply throughout the episode duration. CMS will exclude inpatient hospital readmissions based on the list of excluded MS–DRGs and Part B services that report an excluded ICD–9–CM (or equivalent ICD–10–CM) diagnosis code as the principal diagnosis based on the list posted on the CMS website at: *http://innovation.cms.gov/initiatives/CCJR*. Under the final rule, CMS will exclude OPPS transitional pass-through payments for medical devices from the CCJR model episode definition and price determinations. Finally, CMS will exclude from the CCJR episode definition 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. Hemophilia clotting factors will be paid separately during inpatient hospitalization and not included in the episode definition.

Canceled Episodes
CMS will cancel episodes once they have begun but prior to their end if the beneficiary no longer meets the same inclusion criteria below.

- The beneficiary is readmitted to a participant hospital during the episode and discharged under MS–DRG 469 or 470
- The beneficiary initiates an LEJR episode under BPCI Models 1, 2, 3 or 4
- The beneficiary dies at any time during 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.

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

CMS is modifying its proposed policy on the model performance years and establishing **April 1, 2016**, as the start date for the model, instead of Jan. 1, 2016. The table below (Table 8 in the final rule) includes details on which episodes would be included in each of the five performance years under this delay.

TABLE 8—PERFORMANCE YEARS FOR CJR MODEL

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

Under this revised schedule, all episodes tested in this model will have begun on or after April 1, 2016, and ended on or before Dec. 31, 2020.

CMS will apply the CCJR episode payment methodology retrospectively. A retrospective episode payment approach is currently being utilized under BPCI Model 2. Under this payment methodology, all providers and suppliers caring for Medicare beneficiaries in CCJR episodes will 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 will be grouped into episodes and aggregated. Participant hospitals' CCJR episode quality and actual payment performance will be assessed and compared against episode quality thresholds and target prices. CMS will then determine if Medicare will make a reconciliation payment to the hospital (which would be phased in beginning with year two through five only), or if the hospital will have to repay money to Medicare. CMS believes that not holding hospitals responsible for repaying excess episode spending would reduce the incentives for hospitals to improve quality and efficiency.

To ''phase in'' this two-sided risk, during the first year of a hospital's financial responsibility for repayment (performance year two—there will be no downside responsibility in performance year one), CMS will set an episode target price that partly mitigates the amount that it will 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.

Episode Target Price-Setting Methodology

CMS intends to calculate and communicate episode target prices for MS-DRG 469 and MS-DRG 470 for participant hospitals prior to the performance period in which they apply (that is, prior to Jan. 1, 2017, for target prices covering episodes initiated between Jan. 1, and Sept. 30, 2017; and prior to Oct. 1, 2017, for target prices covering episodes initiated between Oct. 1, and Dec. 31, 2017). CMS modified the proposed rule to risk stratify (and set different target prices) based on not just different anchor MS–DRGs but also patients' hip fracture status (hip fractures vs. without hip fractures). CMS will identify episodes with hip fractures using ICD–9–CM or ICD–10–CM diagnosis codes in the principal position on the claim for the anchor hospitalization. CMS will also institute a subregulatory process in order to allow for public comment and to finalize the ICD–9–CM and ICD–10–CM diagnosis codes to be used in identifying hip fracture cases in the CCJR model, which initiated as of the public release of the final rule.

CMS refers readers to the list of ICD–9–CM diagnosis codes (available in an Excel spreadsheet) posted on the CCJR model website at *http://innovation.cms.gov/initiatives/*. CCJR hospitals will receive separate episode target prices for MS-DRGs 469 and 470, reflecting the differences in spending for episodes initiated by each MS-DRG. In performance years 1, 4, and 5 each participant hospital will have eight potential target prices for each combination of anchor MS–DRG. In performance years 2 and 3 each participant hospital will have 16 target prices for the same combinations in performance years 1, 4, and 5, but with one group of eight potential target prices for purposes of calculating reconciliation payments, and another group of eight potential target prices for purposes of determining hospital's responsibility for excess episode spending.

In response to comments, CMS will implement a specific pricing methodology for hip fracture patients due to the significantly higher spending associated with these more complex cases. A simple risk stratification methodology will be used to set different target prices for patients with hip fractures within each MS-DRG.

CMS will use the following 10 steps to calculate target prices for episodes that begin between Jan. 1 and Sept. 30 (between April 1 and Sept. 30 for performance year 1), as well as for episodes that begin between Oct. 1 and Dec. 31, for each performance year. The output of each step would be used as the input for the subsequent step, unless otherwise noted.

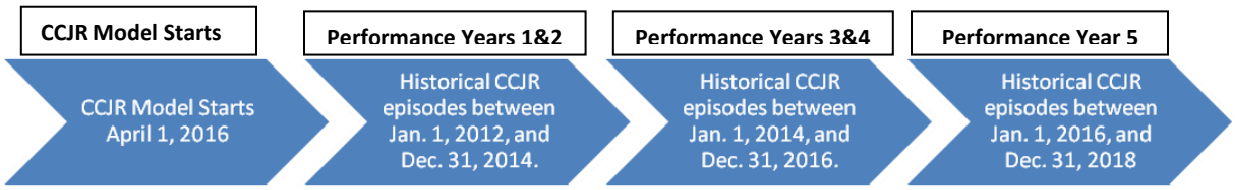
(1) Calculate historical CJR episode payments for episodes that were initiated during the 3-historical-years for all CJR-eligible hospitals for all Medicare Part A and B services included in the episode.
(2) Remove effects of special payment provisions and normalize for wage index differences standardizing Medicare FFS payments at the claim level.
(3) Prorate Medicare payments for included episode services that span a period of care that extends beyond the episode.
(4) Trend forward two oldest historical years of data to the most recent year of historical data.
(5) Cap high episode payment episodes with a region- and MS DRG anchor-specific high payment ceiling using the episode output from the previous step
(6) Calculate anchor factor and participant-hospital-specific weights using the episode output from the previous step to pool together MS DRG 469- and 470-anchored episodes with and without hip fracture, resulting in participant-hospital-specific pooled historical average episode payments. Similarly, calculate region-specific weights to calculate region-specific pooled historical average episode payments.
(7) Calculate participant-hospital-specific and region-specific weighted update factors. Multiply each participant hospital-specific and region-specific pooled historical average episode payment by its corresponding participant hospital-specific and region-specific weighted update factors to calculate participant hospital-specific and region -specific updated, pooled, historical average episode payments.
(8) Blend together each participant hospital-specific updated, pooled, historical average episode payment with the corresponding region-specific updated, pooled, historical average episode payment according to the proportions described in section III.C.4.b.(5) of the final rule.

(9) Multiply the output of step (8) by the appropriate anchor factors (step (6) of this target price calculation process, for MS DRG 469 anchored episodes with hip fracture, MS DRG 469 anchored episodes without hip fracture, and MS DRG 470 anchored episodes with hip fracture. For purposes of the final rule, CMS will define the outputs of this step as the pre-discount target prices for MS DRG 469-anchored episodes with hip fracture, MS DRG 469-anchored episodes without hip fracture, and MS DRG 470-anchored episodes with hip fracture.

(10) Multiply the pre-discount target prices for MS DRGs 469 and 470 episodes with and without hip fracture by the appropriate effective discount factor that incorporates any quality incentive payment, as briefly described in section III.C.4.b.(9) of the final rule, and more specifically detailed in the response to comments in section III.C.5. of the final rule and Tables 19, 20, and 21. The results of these calculations will be participant hospitals' target prices for MS DRG 469-anchored episodes with hip fracture, MS DRG 469-anchored episodes without hip fracture, MS DRG 470-anchored episodes with hip fracture, and MS DRG 470-anchored episodes without hip fracture.

Trending of Historical Data

CMS will use three years of historical CCJR episodes for calculating CCJR target prices. The three historical years used will be updated every other year. The following graphic timeline displays the model's performance periods and the historical episodes for calculating the target prices.



Blend Hospital-Specific and Regional Historical Data

CMS will 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 will 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 will 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 will 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 will trend the historical data to the most recent of the three being used to set target prices, though instead of calculating different national trend factors just for anchor MS–DRGs 469 vs. 470, it will calculate different national trend factors for each combination of anchor MS–DRG (469 vs. 470) and hip fracture status (with hip fracture vs. without hip fracture). Please see the discussion of updates in a following section.

Hospital-Specific and Regional Historical Data Exception

CMS is finalizing its proposal to blend hospital-specific and regional historical expenditures in setting target prices 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. CMS believes that 20 episodes in the 3-historical-years of data used to calculate target prices is the appropriate ''low volume'' threshold for blending target prices that mitigates effects of random variation while still incorporating hospital-specific historical experience and affording participant hospitals an opportunity to transition to 100 percent regional pricing. CMS also believes that only using hospital-specific pricing would not reward already efficient participant hospitals for maintaining high performance; participant hospitals that are already delivering efficient and high quality care would find it challenging to improve upon their own historical performance in order to qualify for reconciliation payments. On the other hand, using the higher of regional and hospital-specific prices would not sufficiently incentivize inefficient participant hospitals to become more efficient

Historical Episode Payment Updates for Ongoing Payment System Updates

CMS is modifying its proposal to update historical episode payments for ongoing payment system (IPPS, OPPS, IRF, PPS, SNF, PFS) updates so as to include in the definition of ''CCJR eligible hospitals'' those that are participants in BPCI Model 1 or in the risk-bearing period of Models 2 or 4 for LEJR episodes, and rename ''CCJR eligible hospitals'' to ''CCJR regional hospitals.'' CMS is also finalizing a modification of how it calculates update factors to more accurately capture payment system rate changes throughout the calendar year for inpatient acute, IRF, and SNF services.

Special Payment Provisions Under Existing Medicare Payment Systems

CMS is finalizing its proposal, without modification, to exclude special payment provisions from episode calculations. CMS clarifies that it will include IPPS capital payments in target price and actual episode expenditure calculations. It also clarifies that it will utilize the CMS Price Standardization approach previously referenced to remove the effect of any current and potential future special payment provisions. CMS may revisit in future rulemaking any modification to its policy to exclude reconciliation and recoupment payments when updating the historical data used to set target prices. Many of the existing Medicare payment systems have special payment provisions to improve quality and efficiency in service delivery. The lists of ICD-9 code ranges for excluded Part B services, MS-DRGs for excluded readmissions, and additional exclusions can be found in ***Appendices 3a-3c*** of this document.

Payment for Services that Extend Beyond the Episode
CMS will prorate payments for services that extend beyond the episode when calculating actual episode payments, setting episode target prices, and calculating reconciliation and repayment amounts. 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.

Pricing Adjustments for High-Payment Episodes
CMS will apply high episode payment ceilings when calculating actual episode payments, setting episode target prices, and calculating reconciliation and repayment amounts. CMS will calculate and apply high payment episode ceilings for each region, anchor MS–DRG, and hip fracture status combination. The high episode payment ceiling will be set at two standard deviations above the mean episode payment amount. For any episode that exceeds that amount, only the cost of the episode included in the reconciliation calculation will be capped at two standard deviations.

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 will normalize for wage indices at the claim level by using the wage index normalization algorithm included in the CMS Price (Payment) Standardization Detailed Methodology. CMS is finalizing the proposal to reintroduce wage index differences into calculations of historical (target price) and actual episode spending based on the participant hospital's wage index and 0.7 as the labor cost share.

Combination of CCJR Episodes
CMS finalizes its proposal, with modification, to calculate anchor factors and hospital and regional weights while incorporating the previously discussed changes to risk adjust not only by anchor MS–DRG but also hip fracture status. Changes to risk stratification would impact how CMS will combine CCJR episodes anchored by MS–DRGs 469 and 470. CMS will risk stratify and set different target prices both for episodes anchored by MS–DRG 469 vs. MS–DRG 470, and for episodes with hip fractures vs. without hip fractures. To fully incorporate this change, it will also modify the proposed approach to calculate anchor factors and hospital and regional weights so as to apply them to four groups of target prices, instead of two groups; otherwise, the approach will be the same as proposed. Specifically, it will have three anchor factors, instead of one:

$$anchor\ factor\ for\ MS-DRG\ 469\ with\ hip\ fracture = \frac{Natl.avg.\ MS-DRG\ 469\ with\ hip\ fracture\ episode\ spend}{Natl.avg.MS-DRG\ 470\ without\ hip\ fracture\ episode\ spend}$$

$$anchor\ factor\ for\ MS-DRG\ 469\ without\ fracture = \frac{Natl.avg.\ MS-DRG\ 469\ without\ hip\ fracture\ episode\ spend}{Natl.avg.MS-DRG\ 470\ without\ hip\ fracture\ episode\ spend}$$

$$anchor\ factor\ for\ MS-DRG\ 470\ with\ hip\ fracture = \frac{Natl.avg.\ MS-DRG\ 470\ with\ hip\ fracture\ episode\ spend}{Natl.avg.MS-DRG\ 470\ without\ hip\ fracture\ episode\ spend}$$

Additionally, hospital and regional weights will be calculated using the following formula:

$$\frac{Count\ of\ MS\ DRG\ 469\ and\ MS\ DRG\ 470\ anchored\ episodes}{\begin{array}{c}MS\ DRG\ 469\ anchored\ with\ hip\ fracture\ episode\ count*anchor\ factor\ for\ MS-DRG\ 469\ with\ hip\ fracture\ +\\ MS-DRG\ 469\ anchored\ without\ hip\ fracture\ episode\ count*anchor\ factor\ for\ MS-DRG\ 469\ without\ fracture+\\ MS-DRG\ 470\ anchored\ with\ hip\ fracture\ episode\ count*anchor\ factor\ for\ MS-DRG\ 470\ with\ hip\ fracture+\\ MS\ DRG\ 470\ anchored\ without\ hip\ fracture\ anchored\ episode\ count\end{array}}$$

Composite Quality Score Methodology

The composite quality score methodology will allow performance on each required quality measure to be meaningfully valued in the model's pay-for-performance methodology, incentivizing and rewarding cost savings in relation to the quality of episode care provided by the participant hospital. The composite quality score will also change the effective discount included in the target price experienced by the hospital at reconciliation for that performance year. This methodology also provides a framework for incorporating additional measures of meaningful outcomes for LEJR episodes in the CCJR pay-for-performance methodology in the future. While it does not set performance thresholds for each measure for reconciliation payment eligibility, it will provide the potential for financial reward for more participant hospitals that reach overall acceptable or better quality performance, thus incentivizing their continued efforts to improve the quality and efficiency of episodes. Quality measures and composite score calculation are discussed in a subsequent section of this summary.

Discount Factor

CMS will use a composite score methodology to link quality and payment in the CCJR model. Hospitals with higher (better) composite quality scores will be subject to a reduced discount factor which in effect either increases the amount they can receive from CMS if their actual costs are less than the target cost or reduces the amount they have to repay CMS.

CMS notes that the lower effective discount factors for calculating repayment amounts in performance years two and three reflect the reduction by 1 percent in discount factor to phase in downside risk. The composite quality score methodology will allow performance on each required quality measure to be meaningfully valued in the model's pay-for-performance methodology, incentivizing and rewarding cost savings in relation to the quality of episode care provided by the participant hospital.

Reconciliation Process

After consideration of the public comments received, CMS is finalizing its proposal, without modification, to conduct a retrospective reconciliation process for the CJR model. Model participants, and all providers and suppliers, will continue to bill and be paid through normal Medicare fee-for-service processes throughout the model for Part A and Part B services furnished to beneficiaries during a CJR episode, with a retrospective reconciliation process after the conclusion of a performance year. CMS will conduct financial reconciliation on an annual basis. It will engage with CJR hospitals throughout the model to ensure the prospective target prices and quarterly data provided to hospitals provide sufficient ongoing feedback and data to hospitals between reconciliations. CMS will perform a reconciliation calculation two months after the conclusion of a performance year, with a subsequent reconciliation calculation 12 months later. This process will allow sufficient time for routine monitoring, review, and adjustment.

CMS is modifying its proposal to calculate the net payment reconciliation amount (NPRA) utilizing the methodology to account for wage index normalization and reintroduction when calculating actual episode expenditures in a performance year, and including the modifications to calculation of target prices and actual episode spending. After the completion of a performance year, CMS will retrospectively calculate a participant hospital's actual episode spending based on the episode definition. Each participant hospital's actual episode payment performance will be compared to its target prices, creating the raw NPRA, and then adjusted for the stop-loss and stop-gain limits, as well as post-episode spending, creating the NPRA.

CMS will 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 will calculate the prior performance year's episode spending a second time during the following performance year's reconciliation process. This will occur approximately 14 months after the end of the prior performance year.

The table below provides the final reconciliation time frames for the model.

TABLE 24—FINAL TIMEFRAME FOR RECONCILIATION IN CJR

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 June 30, 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 CJR hospitals.

The table in ***Appendix 4*** (Table 24 of the final rule) contains the current or forthcoming programs and models with potential overlap with CCJR.

Hospital Responsibility for Increased Post-episode Payments

When hospital repayment responsibility begins in the second performance year of CCJR, hospitals will 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 will apply stop-loss limits of 5 percent in performance year two, 10 percent in performance year three, and 20 percent for performance years four and five. This is a change from the proposed rule where it had proposed to apply stop-loss limits of 10 percent in performance year two, and 20 percent in performance years three through five. CMS believes a gradual transition to downside risk may reduce the effect of random variation in the early years of the model that could result in highly skewed episode costs that would, in turn, result in hospital repayment. One of the goals of this model is to evaluate the generalizability of a bundled payment model for selected hospitals and CMS is interested in evaluating the effects on hospitals for assuming financial responsibility of an episode of care that includes downside risk with limits over time.

- *Stop-Gain Limit*
  CMS will establish stop-gain limits that correspond to the finalized stop-loss limits, such that the stop-gain limit is 5 percent in performance years one and two, 10 percent in performance year three, and 20 percent in performance years four and five. CMS notes that it plans to monitor beneficiary access and utilization of services and the potential contribution of the stop-gain limit to any inappropriate reduction in episode services. CMS believes parallel stop-loss and stop-gain limits are appropriate for the CCJR model

in order to ensure that both CMS and hospitals in the model are similarly at risk for episode spending.

For rural hospitals, SCHs, MDHs, and RRCs, CMS is finalizing a more gradual stop-gain limit where the limit is 5 percent in performance year two, 10 percent in performance year three, and 20 percent in performance years four and five. This additional protection is for these groups of hospitals that may have a lower risk tolerance and less infrastructure and support to achieve efficiencies for high payment episodes. 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 these hospitals. Additionally, CMS will provide a stop-gain limit that corresponds to the finalized stop-loss limits for other hospitals in the model such that this limit is 5 percent in performance years one and two, 10 percent in performance year three, and 20 percent in performance years four and five. The charts below illustrate these final changes.

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%

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

CMS is not finalizing its proposed pay-for-performance threshold methodology to determine a participant hospital's reconciliation payment eligibility if episode savings are achieved beyond the target price. Therefore, it is not finalizing its proposal to reduce the discount percentage to 1.7 percent from 2.0 percent for successful submission of total hip arthroplasty/total knee arthroplasty (THA/TKA) voluntary patient-reported outcomes (PRO), and limited risk variable data. Instead, under its final policy it is incorporating the successful criterion for submission of THA/TKA voluntary PRO and limited risk variable data into its composite quality score methodology for the CCJR model, awarding points to participant hospitals who successfully submit these data that will be added into the calculation of the hospital's composite quality score.

Use of Quality Performance in the Payment Methodology

Incorporating quality performance into the episode payment structure is an essential component of the CCJR model. Participating hospitals must achieve a minimum quality performance composite score in order to be eligible to receive a reconciliation payment under CCJR. CMS finalizes the adoption of the following measures to determine hospital quality of care, and adjust payments to/from hospitals:

- *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.

- *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 Program.

- *THA/TKA Voluntary PRO*: Voluntarily submitted measure of patient outcomes following THA/TKA.

Given that CMS is not adopting the THA/TKA Readmissions measure (NQF #1551) for the CCJR model that it presented in the proposed rule, it will assign more weight than it discussed in the proposed rule to measures of patient experience and functional status.

Quality Measure	Weight in Composite Quality Score (%)
Hospital-level risk-standardized complication rate following elective primary THA and/or TKA (NQF #1550)	50
HCAHPS Survey (NQF #0166)	40
THA/TKA Voluntary PRO	10

Methodology to Link Quality and Payment

As mentioned earlier, CMS is not finalizing its proposal that hospitals could qualify for a lower discount from 2 percent to 1.7 percent applied to their target episode price if they voluntarily submit patient-reported outcome measures data. Rather, it is finalizing the use of a composite

quality score based on achievement and improvement on the THA/TKA Complications measure (NQF #1550) and the HCAHPS Survey measure (NQF #0116), as well as submission of THA/TKA voluntary PRO data, that will assign hospitals to be below acceptable, acceptable, good, and excellent. Hospitals assigned as "below acceptable" will not be eligible for a reconciliation payment and will be subject to a 3 percent discount in calculating their target benchmark for repayment. Hospitals assigned as "acceptable" will be eligible for a reconciliation payment and will be subject to a 3 percent discount. Hospitals assigned as "good" will be eligible for a reconciliation payment and will be subject to a 2 percent discount. Lastly, hospitals assigned as "excellent" will be eligible for a reconciliation payment and will be subject to a 1.5 percent discount. CMS notes that in performance year two and three, the discount for repayment would be 1 percent less than the discount applied for a reconciliation payment. The tables in ***Appendix 5*** of this document (Tables 19, 21, and 21 in the final rule) display the relationship of the composite quality score to reconciliation payment discount percentage.

Performance Periods

In order to align the CCJR program with other CMS hospital quality and public reporting programs, CMS finalizes the three-year rolling performance period as proposed for the THA/TKA Complications measure (NQF #1550). Similarly, for the HCAHPS Survey measure (NQF #0166), CMS finalizes its proposal that the survey scores be calculated from four consecutive quarters of survey data, and that publicly reported HCAHPS results be based on that data. The following table (Table 32 of the final rule) provides a summary of the final quality measure performance periods of the CCJR model by year.

TABLE 32—SUMMARY OF FINALIZED QUALITY MEASURE PERFORMANCE PERIODS BY YEAR OF THE CJR MODEL

Measure title	CJR Model year				
	1st	2nd	3rd	4th	5th
THA/TKA Complications *	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.
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 Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey measure (NQF #0166).

Data Collection for Patient Reported Outcome Measure

CMS is finalizing a lower criterion than proposed for the ''successful'' voluntary patient-reported outcome and limited risk variable data collection for year one, which will entail each participating hospital submitting the required pre- and post-operative data elements (see Table 28 of the final rule for the final list of voluntary patient-reported outcomes and limited risk variable data elements) on either of the following:

- 50 percent of eligible procedures during the data collection period; or
- A total of 50 eligible procedures during the data collection period.

This will allow hospitals the opportunity to actively engage in data collection but, consistent with the experiences reported by several commenters, acknowledges the realities that such systematic data collection efforts require time to implement. The postoperative data collected in year two will correspond to the pre-operative data collected in year one and, similarly, for years three

through five. That is, participant hospitals will collect and submit postoperative data for the same cases for which the hospital submitted preoperative data in the preceding year.

CMS is also finalizing the proposed requirement that the required THA/TKA voluntary PRO data and the limited list of risk variables be submitted to CMS within 60 days of the end of the most recent performance period. CMS believes requirements for the THA/TKA voluntary PRO data and limited list of risk variables that CMS is finalizing will markedly decrease the burden of collecting and submitting the THA/TKA voluntary PRO data by participant hospitals.

Appendix 6 (Table 30 of the final rule) contains the finalized THA/TKA voluntary PRO and limited risk variable data submission performance periods.

Waivers of Medicare Program Rules

CMS is finalizing its proposal, without modification, that waivers of Medicare program rules would apply to the care of beneficiaries who are in CCJR model episodes at the time the service is furnished to the beneficiary under the waiver, even if the episode is later canceled. This policy includes circumstances where a beneficiary's care is ultimately excluded from the CCJR model due to a change in coverage during the episode. 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 a service under a waiver was furnished, CMS will recoup payment for that service from the provider or supplier who was paid. However, for this situation, it is not finalizing its proposal to require that providers or suppliers repay the beneficiary for any coinsurance previously collected. It may consider other approaches to handling these types of issues in the future. In the final rule, CMS addresses the Medicare programmatic waivers it proposed. It declines at this time to waive any additional Medicare programmatic requirements. It will review the information provided by the commenters and its early model experience and may consider waiving additional requirements during the course of the model test.

- *Post-Discharge Home Visits*: Under this waiver, only beneficiaries who meet all program requirements to receive home health services will be eligible for coverage of these health services without being homebound. CMS will not 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 will 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. 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. This code will be payable for CCJR model beneficiaries beginning April 1, 2016, the start date of the first CCJR model performance year.

- *Telehealth Services*: For CCJR model beneficiaries, with the exception of the existing geographic site requirement for a face-to-face encounter for home health certification, CMS will 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. Any service on the list of Medicare-approved telehealth services and reported on a claim with an ICD–10–CM principal diagnosis code that is not excluded from the CCJR episode definition can be furnished to a CCJR beneficiary, regardless of the beneficiary's geographic location. CMS will waive the originating site requirements that specify the particular sites at which the eligible telehealth individual must be located at the time the service is furnished via a telecommunications system only when telehealth services are being furnished in the CCJR beneficiary's home or place of residence during the episode. Any service on the list of Medicare-approved telehealth services and reported on a claim with an ICD–10–CM principal diagnosis code that is not excluded from the CCJR episode definition can be furnished to a CCJR beneficiary in his or her home or place of residence, unless the service's HCPCS code descriptor precludes delivering the service in the home or place of residence. CMS will create nine HCPCS G-codes to report home telehealth E/M visits furnished under the CCJR waiver of telehealth requirements. These codes will be payable for CCJR model beneficiaries beginning April 1, 2016.

- *SNF Three-day Rule:* Because of the potential benefits CMS sees for participating CCJR hospitals, their provider partners, and beneficiaries, CMS will waive the SNF three-day rule for episodes being tested in the CCJR model in performance years two through five, with modification of the SNF quality requirements. CMS will waive the SNF three-day rule for a CCJR beneficiary following the anchor hospitalization only if the SNF is qualified at the time of the CCJR beneficiary's SNF admission. CMS defines a qualified SNF as one that has an overall rating of three stars or better in the Five-Star Quality Rating System for SNFs on the Nursing Home Compare website for at least seven of the 12 preceding months, as determined by CMS based on the most recent rolling 12 months of SNF star rating data available for the calendar quarter that includes the date of the beneficiary's admission to the SNF. CMS will post the list of qualified SNFs quarterly to the CMS web site. If a SNF is on this list, the other requirements for the waiver as listed previously are met, as well as other existing Medicare coverage requirements, the SNF stay for the CCJR beneficiary will be covered under Part A, under the CCJR model SNF three-day rule waiver. Beneficiaries will be able to receive a Part A-covered SNF stay furnished in accordance with the SNF three-day stay rule waiver only during the CCJR episode. All other Medicare rules for coverage and payment of Part A-covered SNF services continue to apply. 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 will 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.

Financial Arrangements with CCJR Collaborators

Given the financial incentives of episode payment in CCJR, participant hospitals in the model might want to engage in financial arrangements to share reconciliation payments or hospital internal cost savings or both, as well as responsibility for repaying Medicare, with providers and suppliers making contributions to the hospital's episode performance on spending and quality. Such arrangements with CCJR collaborators (providers and suppliers), would allow the participant hospitals to share all or some of the reconciliation payments they may be eligible to receive from CMS, or its internal cost savings that result from care for beneficiaries during a CCJR episode. In addition, such arrangements could allow the participant hospitals to share the responsibility for the funds needed to repay Medicare with providers and suppliers engaged in caring for CCJR beneficiaries, if those providers and suppliers have a role in the hospital's episode spending or quality performance.

CCJR collaborators may include the following provider and supplier types:

- Skilled nursing facilities
- Home health agencies
- Long term care hospitals
- Inpatient rehabilitation facilities
- Physician group practices (PGP)
- Physicians, non physician practitioners, and providers and suppliers of outpatient therapy

The CCJR collaborators must directly furnish related items or services to a beneficiary during the episode and/or specifically participate in CCJR model LEJR episode care redesign activities. Under the final rule, in order for a physician or nonphysician practitioner to be a CCJR collaborator, the provider must not have opted out of Medicare, meaning that the individual physician or nonphysician practitioner must be either enrolled in Medicare as a participating physician/supplier or as a non-participating physician/supplier. CMS requires that the participant hospital develop and maintain a written set of policies for selecting its CCJR collaborators. This set of policies must contain criteria for selection of CCJR collaborators that include criteria related to, and inclusive of, the quality of care to be delivered to beneficiaries by the CCJR collaborator during a CCJR episode. All CCJR collaborators must have met, or agree to meet, the quality criteria for selection. The selection criteria cannot be based directly or indirectly on the volume or value of referrals or business otherwise generated by, between, or among the participant hospital and CCJR collaborators, and any individual or entity affiliated with a participant hospital or CCJR collaborator. Finally, all CCJR collaborators must have met, or agree to meet, the quality criteria for selection.

Sharing Arrangements

In the final rule, CMS notes that the term "CCJR sharing arrangement" will now be referred to as the "sharing arrangement," which by definition, documents a financial arrangement between the CCJR collaborator and the participant hospital that is for the purpose of making gainsharing payments or alignment payments, or both. The terms of the sharing arrangements must be set forth in a written agreement between the participant hospital and the CCJR collaborator. Under the final rule, this written agreement is called a "collaborator agreement," not "participation agreement" as proposed. Documentation for collaborator agreements must include a description

of the sharing arrangement, its date, the purpose, the provisions and scope of the arrangement, and the financial terms of the arrangement. The participant hospital will be required to keep contemporaneous documentation of collaborator agreements.

While a collaborator agreement may also address clinical matters, such as care redesign strategies, a provider or supplier is not a CCJR collaborator unless the collaborator agreement signed by the provider or supplier contains a sharing arrangement. Sharing arrangements, included in collaborator agreements, must be entered into before care is furnished to CCJR beneficiaries under the terms of the arrangement. Participant hospitals in the CCJR model that enter into sharing arrangements are responsible for ensuring that those providers and suppliers comply with the terms and requirements of the CCJR model. In the final rule, CMS notes that it has consolidated at §510.500(b) the criteria that each sharing arrangement must satisfy. It has also finalized an extensive list of criteria that each collaborator agreement must include under §510.500(c).

Gainsharing Payments

Gainsharing payment may only be composed of the following:

- Reconciliation payments
- Internal cost savings
- Both

Gainsharing payments must also:

- Be actually and proportionally related to the care of beneficiaries in a CCJR episode
- Be distributed on an annual basis (not more than once per calendar year)
- Not be a loan, advance payments, or payments for referrals or other business

A participant hospital is required to include in its collaborator agreements the methodology it will use to determine gainsharing payments, and this methodology must be based, at least in part, on criteria related to, and inclusive of, the quality of care to be delivered to beneficiaries during a CCJR episode, and not directly on the volume or value of referrals or business generated by providers and suppliers.

PGP Payments

CMS is finalizing its proposal with a modification to allow PGPs that are CCJR collaborators to retain all or a portion of a gainsharing payment that it receives from a participant hospital. CMS believes that this modification will provide greater financial flexibility to PGPs that are CCJR collaborators, and will allow for those PGPs to consider sharing arrangements that contain provisions regarding alignment payments. CMS notes that for purposes of the final rule, a PGP is an entity that furnishes clinical patient care services, including evaluation and management services, or professional surgical services. CMS does not believe that an entity is a PGP if it merely furnishes supplies or tests to patients. In order to be eligible to receive a gainsharing payment, the PGP that is a CCJR collaborator must meet certain criteria.

CMS emphasizes that a PGP that is a CCJR collaborator is not obligated under the final rule to distribute (make a ‘‘distribution payment’’) a gainsharing payment to its PGP members. Upon receipt of a gainsharing payment, the PGP may retain some or all of the gainsharing payment. If the PGP chooses to make distribution payments, it must do so only in accordance with a distribution arrangement. All distribution arrangements must comply with all applicable laws and regulations, including the applicable fraud and abuse laws, and the criteria specified in the final rule.

These and other important provisions pertaining to gainsharing payments finalized in the rule can be found in ***Appendix 7*** of this document.

Alignment Payments

Alignment payments are those where the hospital and CCJR collaborator agree through a sharing arrangement to share risk for repayment amounts due to CMS, as reflected on a CCJR reconciliation report. Accordingly, any alignment payments that the participant hospital receives through a sharing arrangement must meet the requirements set forth in the final rule and be administered by the participant hospital in accordance with generally accepted accounting principles. Further, any alignment payments made pursuant to a sharing arrangement may be made only to the participant hospital from the entity or individual with whom it has signed a collaborator agreement. Alignment payments from a CCJR collaborator to a participant hospital may be made at any interval that is agreed upon by both parties, and must:

- Not be issued, distributed, or paid prior to the calculation and issuance by CMS of a reconciliation report reflecting a repayment amount
- Not be a loan, advance payments, or payments for referrals or other business

In a calendar year, the aggregate amount of all alignment payments received by the participant hospital must not exceed 50 percent of the participant hospital’s repayment amount. Also, no alignment payments may be collected by a participant hospital if it does not owe a repayment amount. Further, the aggregate amounts of all alignment payments from any one CCJR collaborator to a participant hospital must not be greater than 25 percent of the participant hospital’s repayment amount.

Records Retention

CMS requires 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 will 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 clarifies that the CCJR episode items and services may be provided by the hospital through an agent who is under the hospital's direction and control. CMS notes that if a reasonable beneficiary would perceive the item or service as being from the agent rather than the hospital, it would not consider the incentive to have been provided by the hospital. CMS also clarifies the following:

- The items and services must be reasonably connected to medical care provided to a beneficiary ''during an episode.''
- The item or service must be a preventive care item or service or advance a clinical goal for a beneficiary in a CCJR episode.
- The item or service must not be tied to the receipt of items or services outside of the episode of care.

At the suggestion of the commenters, CMS is adding new provisions to require that:

1. The item or service may not be tied to receipt of items or services from a particular provider or supplier.
2. The availability of the items or services must not be advertised or promoted, except that a beneficiary may be made aware of the availability of the items or services at the time the beneficiary could reasonably benefit from them.
3. The cost of the items or services must not be shifted to another federal healthcare program.

CMS finalizes the proposed documentation requirement for beneficiary incentives with certain changes. It will apply only to those items and services furnished as beneficiary incentives whose retail value exceeds $25, and it requires contemporaneous documentation to be retained for 10 years. As no commenters objected to the proposed limit of $1,000 in retail value for items and services involving technology provided to any one beneficiary in any one CCJR episode, CMS is finalizing this requirement. Also, items or services involving technology provided to a beneficiary must be the minimum necessary to advance a clinical goal for a CCJR beneficiary. Lastly, CMS is modifying the requirement that items of technology furnished as beneficiary incentives remain the property of the participant hospital and be retrieved from the beneficiary at the end of the model to apply only to those items of technology that exceed $100 in retail value.

Fraud and Abuse Laws

CMS believes waivers 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. These waivers would be promulgated separately from the final regulation by the Office of Inspector General (OIG) and CMS. CMS notes that any fraud and abuse waivers issued in connection with the CCJR model will be available at https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Fraud-and-Abuse-Waivers.html, and also on OIG's website. The

notice of waivers issued by the OIG in conjunction with the final rule can be found at https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/2015-CJR-Model-Waivers.pdf. No waivers of any fraud and abuse authorities are being issued in the final rule.

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:* This model does not limit the ability to choose among Medicare providers or the range of services available to the beneficiary. Beneficiaries may continue to choose any Medicare participating provider, or any physician or practitioner who has opted out of Medicare, with the same costs, copayments, and responsibilities as they have with other Medicare services regardless of whether the provider or supplier is a participant hospital or has entered into a sharing arrangement with a participant hospital. Physicians and hospitals may identify and recommend ‘‘preferred providers,’’ a term used to include both providers and suppliers, which may include but are not limited to CCJR collaborators with sharing arrangements with the participating hospital, as long as such recommendations do not result in violations of current laws or regulations. However, participant hospitals may not restrict beneficiaries to any such list of preferred or recommended providers/suppliers and must clearly advise beneficiaries that their choices are not constrained. Moreover, hospitals may not charge any CCJR collaborator a fee to be included on any list of preferred providers or suppliers, nor may the hospital accept such payments, which would be considered to be outside the realm of risk-sharing agreements. Thus, this payment model does not create any restriction of beneficiary freedom to choose providers and suppliers, including surgeons, hospitals, PAC, or any other providers or suppliers.

- *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 finalizes its proposal to require that hospitals in the CCJR model notify beneficiaries of the requirements surrounding the model at the point of admission to the hospital and modifies its proposal to add additional detail to the content, timing, and form of its notification requirements in response to comments. CMS will continue to require participant hospitals to provide beneficiaries with a general notice of the existence of the model and of certain beneficiary rights at admission. CMS also requires that as a condition of any Sharing Arrangement that participant hospitals require the collaborators to notify beneficiaries of the existence of a sharing arrangement. In the case of

physicians, this notification must occur at the point of the decision to proceed to surgery, or, in the case of other collaborators, prior to the furnishing of the first service provided by the collaborator that is related to the joint replacement. CMS modifies its PAC notification requirements, specifying that participant hospitals, as part of discharge planning, must inform beneficiaries of all Medicare participating PAC providers/suppliers in an area, but may identify those providers/suppliers that the hospital considers to be preferred. To increase beneficiary awareness CMS specifies that the participant hospital must also, inform the beneficiary of providers/suppliers with whom a Sharing Arrangement exists. Participant hospitals are required to reference the most recently published CMS list of SNFs, which qualify for the waiver of the three-day rule.

- *Monitoring for Quality of Care:* CMS finalizes its proposal to use its existing authority to audit claims and services, use Quality Improvement Organizations to assess for quality issues, use its authority to investigate allegations of patient harm, and monitor the impact of the quality metrics that it finalizes. The potential for the denial of medically necessary care within the CCJR model will not be greater than that which currently exists under IPPS. However, CMS believes that it 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. With respect to PAC, CMS believes that requiring participating hospitals to engage patients in shared decisionmaking 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 any Sharing Arrangements with practitioners who perform these procedures although CMS did not propose any regulations text. In any payment system that promotes efficiencies of care delivery there may be opportunities to direct patients away from more expensive services at the expense of outcomes and quality. CMS believes that professionalism, the quality measures in the model, and clinical standards can be effective in preventing beneficiaries from being denied medically necessary care in the inpatient setting and in PAC settings during the 90 days post discharge.

Data Sharing Specifications

CMS will share data with participant hospitals upon request throughout the performance period of the CCJR model to the extent permitted by the HIPAA Privacy Rule and other applicable law. Both raw claims-level data and claims summary data will be shared with participants upon request. This approach will allow participant hospitals without prior experience analyzing claims to use summary data to receive useful information, while allowing those participant hospitals who prefer raw claims-level data the opportunity to analyze claims. Hospitals will be provided with up to three years of retrospective claims data upon request that will be used to develop their target price. In accordance with the HIPAA Privacy Rule, CMS will limit the content of this data set to the minimum data necessary for the participant hospital to conduct quality assessment and improvement activities, and effectively coordinate care of its patient population.

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. CMS will make available to participant hospitals, through the most appropriate means, data that it determines may be useful to participant hospitals. CMS is also finalizing its proposal to exclude information that is subject to the regulations governing the confidentiality of alcohol and drug abuse patient records from any beneficiary-identifiable claims data shared with a hospital at this time.

CMS will make beneficiary claims information available through two formats:

- First, for participant hospitals that lack the capacity to analyze raw claims data, CMS will 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 will 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 will provide CCJR hospitals with aggregate data on the total expenditures during an acute inpatient stay and 90-day post-discharge period for all Medicare FFS beneficiaries whose anchor diagnosis at discharge was either MS–DRG 469 or 470 (and would have initiated a CCJR episode if discharged from a CCJR hospital) in their census region. CMS will also consider the range of comments it received on the additional kinds of data elements and formats that would be most useful to participating hospitals. In the event it considers adopting additional elements or formats for these data, it will provide further guidance, potentially through rulemaking if warranted.

Timing and Period of Baseline Data

CMS finalizes its proposal to make three years of baseline data available to hospitals and intends to make these data available, upon request, before the April 1, 2016, start date.

Frequency and Period of Claims Data Updates
CMS modifies its proposal to no longer limit the availability of updated claims data available to hospitals upon receipt of a request for the information that meets its requirements to ensure the applicable HIPAA conditions for disclosure have been met, from a frequency of ‘‘no more often than once a quarter’’ to instead ‘‘no less frequently than on a quarterly basis,’’ with the goal of making these data available as frequently as on a monthly basis if practicable. This modification would apply to both beneficiary-identifiable claims data (line-and summary-level) and aggregate regional data. CMS also clarifies that in order to receive data during participation in the model, a hospital need only make a single initial request rather than multiple periodic requests.

Sharing Beneficiary-Identifiable Data
CMS is not finalizing its proposal permitting beneficiaries the choice to opt out of having their beneficiary-identifiable data shared. CMS will make these data available to participant hospitals, upon request and in accordance with the HIPAA Privacy Rule. CMS will not, however, be providing beneficiary-identifiable data under this model to collaborators within the model or entities that are not participating in the model. CMS notes that this does not preclude beneficiaries from exercising their right to request restrictions on the use of their data either with the participant hospital or with CMS by contacting 800-MEDICARE, through which they can speak with a customer service representative who can address their concern.

CCJR Beneficiary Overlap with Bundled Payments for Care Improvement (BPCI) Episodes
CMS will apply precedence to BPCI Model 2 and Model 3 Physician Group Practice (PGP) and PAC LEJR episodes. By precedence, it means that if for any portion of a CCJR model episode, a beneficiary would also be in a BPCI LEJR episode under Model 2 or Model 3, it will cancel (or never initiate) the CCJR episode. Specifically, if at any time during a beneficiary’s CCJR LEJR episode, that beneficiary would also be in a BPCI Model 2 or Model 3 LEJR episode, the beneficiary’s CCJR episode would either not be initiated or would be canceled such that it would not be included in the participant hospital’s CCJR reconciliation where actual episode spending is compared to the target price. CMS will allow for overlap between the period of time in which a beneficiary is in a CCJR episode and a BPCI non-LEJR episode.

- *Accounting for CCJR Reconciliation Payments and Repayments in Other Models and Programs*: CMS will make reconciliation and repayment amounts under the CCJR model available to other models and programs to include in their financial reconciliation calculations. Both BPCI and the CCJR model share the common episode-initiating event of an inpatient hospitalization and, in the case of each of these models as designed, CMS has concluded that the same savings attribution policy is appropriate. CMS will 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 will 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 will not make separate payments to, or collect repayments from, participating CCJR hospitals for each individual episode, but, will instead, make a single aggregate reconciliation payment or repayment determination for all episodes for a single performance year. CMS will 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. As CMS develops other episode payment models in the future and consider the potential for expansion of successful episode payment models, it will considers the perspectives offered by the commenters on the CCJR model in the design of those models as CMS develops overlap policies or consider changes to existing policies. Thus, CMS will attribute savings achieved (via reconciliation payments) during CCJR episodes to CCJR participant hospitals.

- *Accounting for Per-Beneficiary-Per-Month (PBPM) Payments in the Episode Definition*: CMS will include PBPM payments that are funded with Medicare Part A or Part B Trust Fund dollars, if the services would not otherwise be excluded under the model episode definition. PBPM payments would be included in CCJR model financial calculations only for historical and performance periods during which the model with a PBPM is active and the PBPM is funded with Trust Fund dollars.

  There are currently five CMS models that pay PBPM payments to providers for new or enhanced services, as displayed in Table 25 of the final rule.

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

  As discussed in section III.C.7. of the final rule, the OCM and MCCM PBPM payments will be excluded from the CCJR model payment calculations. Therefore, the remaining models, CPCI, MAPCP, and Million Hearts, will be included in the payment calculation.

  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 will 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 will 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 episode definition for the CCJR model. PBPM payments funded through the Center for Medicare and Medicaid Innovation'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

CMS will account for overlap with non-ACO total cost of care models and ACO models and programs. In cases where a portion of the CCJR discount percentage is paid out as savings to a non-ACO model participant, the other model will make an adjustment to their financial reconciliation calculation to the extent feasible, for non-ACO total cost of care models to adjust their financial reconciliation calculations to the extent feasible to ensure that a portion of the CCJR discount is not paid out as savings under that model. In the case of such overlap with an entity participating in the Shared Savings Program or an ACO model, the CCJR model would require repayment of the portion of the discount percentage paid out as savings through the subsequent reconciliation process, by making an adjustment to the reconciliation amount if available. CMS will make an adjustment to a CCJR hospital's subsequent reconciliation calculation, when the CCJR hospital also participates in the ACO and the beneficiary in the CCJR episode is also assigned to that ACO, to account for when a portion of the CCJR discount percentage is paid out as shared savings to the ACO. If a CCJR hospital did not earn a reconciliation payment, the adjustment would not be made. That is, CMS will not increase the amount of a hospital's repayment amount in order to account for the portion of the discount percentage paid out as savings. This adjustment would only be undertaken when the CCJR hospital is also aligned to an ACO as a participant or a provider/supplier and the beneficiary in the CCJR episode was assigned or aligned to the ACO. CMS may revisit its approach to accounting for overlap with the Shared Savings Program and ACO models in future rulemaking.

Appeals and Reconciliations

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

- *Payment:* The following appeals processes will apply to the following payment and reconciliation processes:
  - For performance year one, if the CCJR Reconciliation Report indicates the reconciliation amount is positive, CMS would issue a payment for that amount to the awardee within 30 calendar days from the issue date of the CCJR Reconciliation Report, unless the participant hospital selects to pursue the calculation error and reconsideration review processes, in which case payment would be delayed. If the CCJR reconciliation report indicates a repayment amount, the participant hospital would not be required to make payment for that amount to CMS, as it will not hold hospitals financially responsible for negative NPRAs for the first performance year.
  - Starting with the reconciliation for 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 from the issue date of the CCJR Reconciliation Report.
  - The reconciliation or repayment amount may include adjustments, arising from matters from the previous performance year, as necessary to account for subsequent calculations performed for performance years that were specified in earlier CCJR Reconciliation Reports.

- If the participant hospital fails to pay CMS the amount owed by the date indicated in the demand letter it sends to the provider, CMS will recoup owed monies from participant hospital's present and future Medicare payments to collect all monies due.

While CMS proposed that a participant hospital may enter into financial arrangements with CCJR collaborators that allow for some risksharing, the participant hospital would be solely liable for the repayment of the negative repayment amount to CMS. Where the participant 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 U.S. Department of the Treasury.

- *Calculation Error:*
  Upon receipt of its CCJR reconciliation report, the participant hospital may choose to submit a calculation error form. The form must be submitted in a form and manner specified by CMS, and be used to contest matters related to payment or reconciliation, of which the following is a non-exhaustive list:

  - The calculation of the participant hospital's reconciliation amount or repayment amount as reflected on a CCJR reconciliation report
  - 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

  Unless the participant provides such notice, the reconciliation report will be deemed final within 45 calendar days after it is issued, and CMS will proceed with payment or repayment. If CMS receives a timely notice of an error in the calculation, CMS will respond in writing within 30 calendar days to either confirm or refute the calculation error, although CMS reserves the right to an extension upon written notice to the participant hospital. If a participant hospital does not submit timely notice of calculation error in accordance with the timelines and processes specified by CMS, the participant hospital is precluded from later contesting matters contained in the CCJR reconciliation report for that performance year.

Dispute Resolution

CMS finalized its dispute resolution proposal without modification. A participant hospital may appeal an initial determination that is not precluded from administrative or judicial review by requesting reconsideration review by a CMS official. The request for review must be submitted for receipt by CMS within 10 days of the notice of the initial determination, in a form and manner specified by CMS. Only a participant hospital may utilize the dispute resolution process. In order to access the dispute resolution process, a participant hospital must timely submit a calculation error form, as previously discussed, for any matters related to payment. If the participant hospital does timely submit a calculation error form and it is dissatisfied with CMS's

response to its calculation error form, the hospital is permitted to request reconsideration review by a CMS reconsideration official.

The reconsideration review request must provide a detailed explanation of the basis for the dispute and include supporting documentation for the participant hospital's assertion that CMS or its representatives did not accurately calculate the NPRA or post-episode spending amount in accordance with CCJR rules. The CMS reconsideration official will make reasonable efforts to notify the hospital in writing within 15 calendar days of receiving the participant hospital's reconsideration review request of the date and time of the review, the issues in dispute, the review procedures, and the procedures (including format and deadlines) for submission of evidence (Scheduling Notice). The CMS official will make reasonable efforts to schedule the review to occur no later than 30 calendar days after the date of the Scheduling Notice. Finally, the CMS official will make reasonable efforts to issue a written determination within 30 days of the review. The determination will be final and binding.

Enforcement Mechanisms

CMS finalizes its proposal with modification to apply these enforcement mechanisms only to participant hospitals. 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 is necessary and appropriate. CMS must have certain mechanisms to enforce compliance with the requirements of the model, either by the participant hospital, or by an entity or individual included in the CCJR model by furnishing a service to a beneficiary during a CCJR episode.

CMS has also included a non-exhaustive list of examples of behaviors that may lead to application of these enforcement mechanisms, which include the following:

- 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 will have the option to use any one or more of the following enforcement mechanisms for participant hospitals in CCJR. These enforcement mechanisms may be instituted and applied in any order, as is consistent with other CMS models:

Warning letter: CMS has the authority to issue a warning letter to participant hospitals to put them on notice of behavior that may warrant additional action by CMS. This letter will inform participant hospitals of the issue or issues identified by CMS leading to the issuance of this enforcement mechanism.

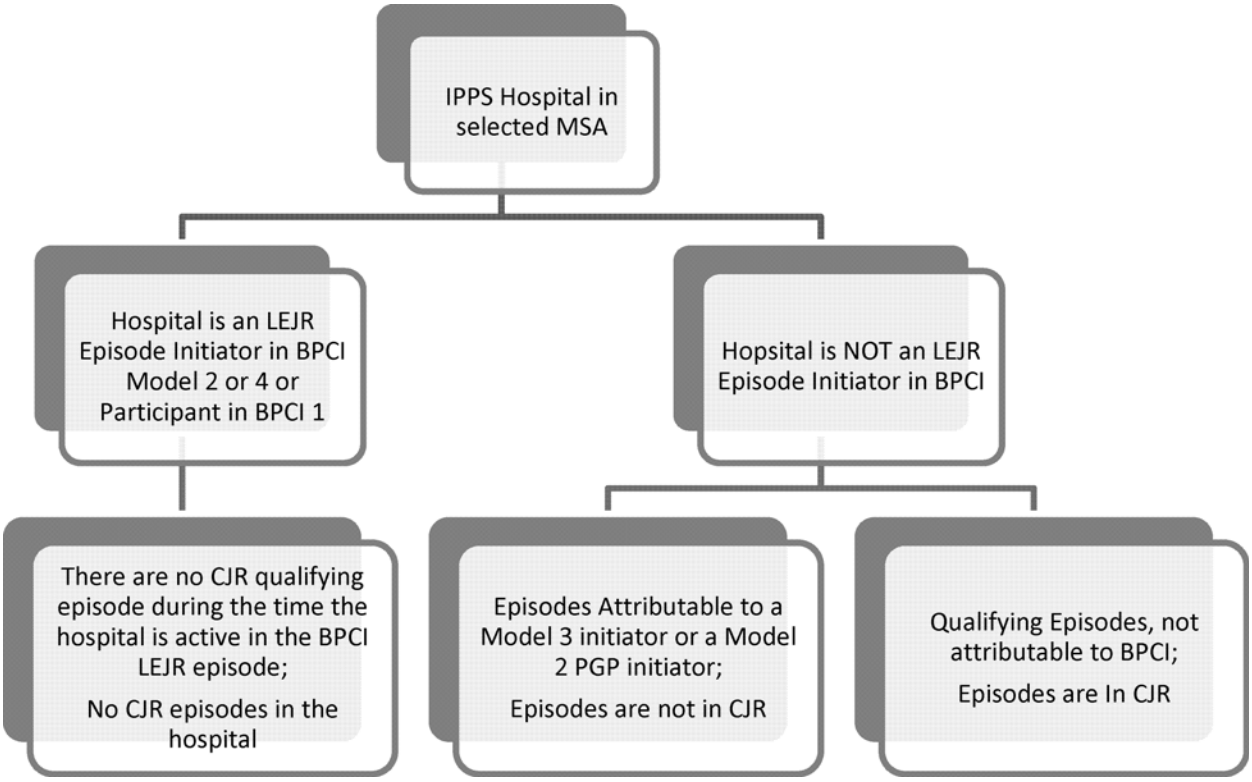
Corrective Action Plan: CMS has the authority to request a corrective action plan from participant hospitals.

Reduction or Elimination of Reconciliation Amount: CMS has the authority to reduce or eliminate a participant hospital's reconciliation payment based on noncompliance with the model's requirements, negative results found through CMS's monitoring activities, or the participant hospital's noncompliance associated with a corrective action plan. Where the participant hospital's reconciliation report reflects a repayment amount, forfeiture of a reconciliation payment would not be an option for that performance year. Therefore, CMS will add 25 percent to a repayment amount on a reconciliation report, where the participant hospital fails to timely comply with a corrective action plan, or is otherwise noncompliant with the model's requirements.

Termination: CMS may terminate a participant hospital from the CCJR model if the participant hospital or its CCJR collaborator that has a Collaborator Agreement with a participant hospital and performs functions or services related to CCJR activities, fails to comply with any of the requirements of the CCJR model or is noncompliant in other respects. The effect of termination from the model is that the hospital would no longer be a participant hospital in the CCJR model. CMS notes, however, that any information collected by CMS in relation to termination of a hospital from the model would be shared with its program integrity colleagues at HHS, the Department of Justice, and their designees. CMS may terminate a participant hospital's participation in the model, or require a participant hospital to terminate a collaborator agreement with a CCJR collaborator.

More Information
Read the final rule, published in the Nov. 24, 2015, *Federal Register*.

Appendix 1: Inclusion of Episodes in CCJR relative to BPCI



Appendix – Final MSAs Included in the CCJR Model

TABLE 4—MSAS INCLUDED IN THE CJR MODEL

MSA	MSA Name
10420	Akron, OH

MSA	MSA Name
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

Appendix 2 – Final MSAs Included in the CCJR Model - Continued

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
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

Appendix 2 – Final MSAs Included in the CCJR Model - Continued

TABLE 4—MSAS INCLUDED IN THE CJR MODEL—Continued

MSA	MSA Name
46220	Tuscaloosa, AL
46340	Tyler, TX
48620	Wichita, KS

Appendix 3a – Primary ICD-9 Code Ranges for Excluded Part B Services in CCJR as of April 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	miliary 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	menigitis 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 venereal 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	menigitis 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	chronic 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 3b - MS-DRGs for Excluded Readmissions in CJR after April 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	bone marrow transplant
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	autologous bone marrow transplant
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 cc/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 mcc
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	endovascular cardiac valve replacement w mcc
267	endovascular cardiac valve replacement w/o mcc
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/mcc
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
490	back & neck proc exc spinal fusion w cc/mcc or disc device/neurostim
491	back & neck proc exc 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	back & neck proc exc spinal fusion w mcc or disc device/neurostim
519	back & neck proc exc spinal fusion w cc
520	back & neck proc exc spinal fusion w/o cc/mcc
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 cc/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 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 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/o 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 3c – Additional Exclusions Effective April 1, 2016

Exclusion
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
OPPS transitional pass-through payments for medical devices on OPPS hospital outpatient claims, identified through HCPCS codes for items assigned OPPS status indicator H

Appendix 4: Models with Potential Overlap with CCJR

TABLE 25—CURRENT PROGRAMS AND MODELS WITH POTENTIAL OVERLAP WITH CJR MODEL

Program/model	Brief description	Shared savings?	Per-beneficiary-per-month (PBPM) payments?
Pioneer ACO Model	ACO shared savings model	Yes	No.
Medicare Shared Savings Program (Shared Savings Program).	ACO shared savings program	Yes	No.
Next Generation ACO Model *	ACO shared savings model	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 PAC services or both.	No	No.
Oncology Care Model (OCM) *	Multi-payer model for oncology physician group practices (PGPs).	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 (MCCM) *	Hospice concurrent care model	No	Yes.

* Denotes model in pre-implementation phase.

Appendix 5: Composite Quality Score and Reconciliation Payment Relationship

TABLE 19—PERFORMANCE YEAR 1: RELATIONSHIP OF COMPOSITE QUALITY SCORE TO RECONCILIATION PAYMENT ELIGIBILITY AND THE EFFECTIVE DISCOUNT PERCENTAGE EXPERIENCED AT RECONCILIATION

Composite quality score	Quality category	Eligible for reconciliation payment	Eligible for quality incentive payment	Effective discount percentage for reconciliation payment (%)	Effective discount percentage for repayment amount
<4.0	Below Acceptable	No	No	3.0	Not applicable.
≥4.0 and <6.0	Acceptable	Yes	No	3.0	Not applicable.
≥6.0 and ≤13.2	Good	Yes	Yes	2.0	Not applicable.
>13.2	Excellent	Yes	Yes	1.5	Not applicable.

TABLE 20—PERFORMANCE YEARS 2 AND 3: RELATIONSHIP OF COMPOSITE QUALITY SCORE TO RECONCILIATION PAYMENT ELIGIBILITY AND THE EFFECTIVE DISCOUNT PERCENTAGE EXPERIENCED AT RECONCILIATION

Composite quality score	Quality category	Eligible for reconciliation payment	Eligible for quality incentive payment	Effective discount percentage for reconciliation payment (%)	Effective discount percentage for repayment amount
<4.0	Below Acceptable	No	No	3.0	2.0
≥4.0 and <6.0	Acceptable	Yes	No	3.0	2.0
≥6.0 and ≤13.2	Good	Yes	Yes	2.0	1.0
>13.2	Excellent	Yes	Yes	1.5	0.5

TABLE 21—PERFORMANCE YEARS 4 AND 5: RELATIONSHIP OF COMPOSITE QUALITY SCORE TO RECONCILIATION PAYMENT ELIGIBILITY AND THE EFFECTIVE DISCOUNT PERCENTAGE EXPERIENCED AT RECONCILIATION

Composite quality score	Quality category	Eligible for reconciliation payment	Eligible for quality incentive payment	Effective discount percentage for reconciliation payment (%)	Effective discount percentage for repayment amount
<4.0	Below Acceptable	No	No	3.0	3.0
≥4.0 and <6.0	Acceptable	Yes	No	3.0	3.0
≥6.0 and ≤13.2	Good	Yes	Yes	2.0	2.0
>13.2	Excellent	Yes	Yes	1.5	1.5

Appendix 6: Final Performance Periods for THA/TKA Voluntary Data Submission

TABLE 30—FINALIZED PERFORMANCE PERIODS FOR PRE- AND POST-OPERATIVE THA/TKA VOLUNTARY DATA SUBMISSION

Model year	Performance period	Duration of the performance period	Patient population eligible for THA/TKA voluntary data submission	Requirements for successful THA/TKA voluntary data submission
2016	July 1, 2016 through August 31, 2016.	2 months	All patients undergoing elective primary THA/TKA procedures performed between July 1, 2016 and August 31, 2016.	Submit PRE-operative data on primary elective THA/TKA procedures for ≥50% or ≥50 eligible procedures performed between July 1, 2016 and August 31, 2016.
2017	July 1, 2016 through August 31, 2016.	13 months ...	All patients undergoing elective primary THA/TKA procedures performed between July 1, 2016 through August 31, 2016.	Submit POST-operative data on primary elective THA/TKA procedures for ≥50% or ≥50 eligible procedures performed between July 1, 2016 through August 31, 2016.
2017	September 1, 2016 through June 30, 2017.	.....	All patients undergoing elective primary THA/TKA procedures performed between September 1, 2016 through June 30, 2017.	Submit PRE-operative data on primary elective THA/TKA procedures for ≥60% or ≥75 procedures performed between September 1, 2016 through June 30, 2017.
2018	September 1, 2016 through June 30, 2017.	22 months ...	All patients undergoing elective primary THA/TKA procedures performed between September 1, 2016 and June 30, 2017.	Submit POST-operative data on primary elective THA/TKA procedures for ≥60% or ≥75 procedures performed between September 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 ≥70% or ≥100 procedures performed between July 1, 2017 and June 30, 2018.
2019	July 1, 2017 through June 30, 2018.	24 months ...	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 ≥70% or ≥100 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% or ≥200 procedures performed between July 1, 2018 and June 30, 2019.
2020	July 1, 2018 through June 30, 2019.	24 months ...	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% or ≥200 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% or ≥200 procedures performed between July 1, 2019 and June 30, 2020.

Appendix 7: Final Gainsharing Payment Provisions

- A participant hospital must not make a gainsharing payment to a CCJR collaborator that is subject to any action for noncompliance with this part of the fraud and abuse laws, or for the provision of substandard care in CCJR episodes or other integrity problems.

- In a calendar year, the aggregate amount of all alignment payments received by the participant hospital must not exceed 50 percent of the participant hospital's repayment amount. No alignment payments may be collected by a participant hospital if it does not owe a repayment amount.

- In a calendar year, the aggregate amount of all gainsharing payments distributed by a participant hospital that are derived from a CCJR reconciliation payment may not exceed the amount of the reconciliation payment the participant hospital receives from CMS.

- The aggregate amounts of all alignment payments from any one CCJR collaborator to a participant hospital must not be greater than 25 percent of the participant hospital's repayment amount.

- A sharing arrangement must not induce the participant hospital, CCJR collaborator, or any employees or contractors of the participant hospital or CCJR collaborator to reduce or limit medically necessary services to any Medicare beneficiary.

- A sharing arrangement must not restrict the ability of a CCJR collaborator to make decisions in the best interests of its patients, including the selection of devices, supplies, and treatments.

- The methodology for determining gainsharing payments must be based, at least in part, on criteria related to, and inclusive of, the quality of care to be delivered to CCJR beneficiaries during an episode and must not directly account for the volume or value of referrals or business otherwise generated by, between or among the participant hospital, CCJR collaborators, and any individual or entity affiliated with a participant hospital or CCJR collaborator.

- The methodology for determining alignment payments must not directly account for the volume or value of referrals or business otherwise generated by, between or among the participant hospital, CCJR collaborators, and any individual or entity affiliated with a participant hospital or CCJR collaborator.

- The total amount of a gainsharing payment for a calendar year paid to an individual physician or nonphysician practitioner who is a CCJR collaborator must not exceed 50 percent of the total Medicare approved amounts under the Physician Fee Schedule (PFS) for services furnished to the participant hospital's CCJR beneficiaries during a CCJR episode by that physician or nonphysician practitioner.

Appendix 7: Final Gainsharing Payment Provisions - Continued

- The total amount of gainsharing payments for a calendar year paid to a PGP that is a CCJR collaborator must not exceed 50 percent of the total Medicare approved amounts under the Physician Fee Schedule (PFS) for services that are billed by the PGP and furnished during a calendar year by members of the PGP to the participant hospital's CCJR beneficiaries during CCJR episodes.

- The participant hospital's determination of internal cost savings must satisfy the following criteria:
    - Internal cost savings are calculated in accordance with generally accepted accounting principles (GAAP) and Government Auditing Standards (The Yellow Book).
    - All amounts determined to be internal cost savings must reflect actual, internal cost savings achieved by the participant hospital through implementation of care redesign elements identified and documented by the participant hospital. Internal cost savings do not include savings realized by any individual or entity that is not the participant hospital.
    - Internal cost savings may not reflect ''paper'' savings from accounting conventions or past investment in fixed costs.

- All gainsharing payments and any alignment payments must meet the requirements set forth in this section and be administered by the participant hospital in accordance with generally accepted accounting principles. In no event may the participant hospital receive any amounts from a CCJR collaborator under a sharing arrangement that are not alignment payments.

- All gainsharing payments and alignment payments must be made through electronic funds transfers.