## Overview of the CMS Comprehensive Care for Joint Replacement Model

**In brief:** On November 16, the Centers for Medicare & Medicaid Services (CMS) released a final rule implementing a mandatory payment bundling model for hospitals in select geographic areas. The Comprehensive Care for Joint Replacement (CJR) Model focuses on bundled payments to acute care hospitals for hip and knee replacement surgery and begins April 1, 2016. NAACOS submitted comments to CMS on the proposed rule urging a number of changes, and we were disappointed that the final rule does not provide the opportunity for Medicare ACOs to share in CJR savings and does not incentivize ACOs and CJR hospitals to partner in coordinating beneficiary care. NAACOS will continue to work with CMS on areas where the CJR Model overlaps with or impacts the Medicare Shared Savings Program. NAACOS released a statement on the final rule, which is available here.

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**Background:** In early 2015, Health and Human Services (HHS) Secretary Sylvia Burwell announced a goal to have 30 percent of all Medicare fee-for-service payments made via alternative payment models by 2016 and 50 percent by 2018. CMS is focused on achieving those targets in a number of ways, including the CJR Model, which is unique in that it is a mandatory program for hospitals in select geographic areas. According to CMS, the CJR Model is designed to incentivize the delivery of high quality, well-coordinated, efficient care over the full episode of care and will encourage hospitals to work more collaboratively with physicians and post-acute providers.

**Program participants:** The CJR Model will include participant hospitals located in 67 Metropolitan Statistical Areas (MSAs) throughout the country. Acute care hospitals paid under the Inpatient Prospective Payment System (IPPS) and located in the selected MSAs will be included in the model, and CMS indicated that approximately 800 hospitals will be required to participate. The list of MSAs included in the CRJ Model is available on this CMS CJR website. Hospitals currently participating in Models 1, 2 or 4 of the Bundled Payments for Care Improvement initiative for lower extremity joint replacement episodes are excluded from the CJR program. There is no application process for the model, and hospitals outside the impacted MSAs are unable to participate.

**Services and procedures:** The CJR Model focuses on lower extremity joint replacement, targeting hip and knee replacement surgeries as identified by MS-DRG 469 (major joint replacement or reattachment of lower extremity with major complications or comorbidities) or 470 (major joint replacement or reattachment of lower extremity without major complications or comorbidities). An episode of care begins when a Medicare fee-for-service beneficiary is admitted to a participant hospital and lasts through 90 days post-discharge. The bundle includes all related items and services paid under Medicare Part A and Part B with the exception of certain exclusions.

**Timeframe:** The CJR Model begins April 1, 2016, and the first program year will be April 1 through December 31, 2016. Beginning in 2017 the CJR will evaluate participant hospitals based on a full year performance period and the program is scheduled to run for five program years, concluding at the end of 2020.

**Financial impact:** Participant hospitals will be evaluated based on their cost and quality during a CJR episode of care (admission through 90 days post-discharge). During the performance years, providers and suppliers will be paid for episode services under the existing Medicare payment systems, such as the IPPS or Medicare physician fee schedule. In the first year of the program, participant hospitals will be eligible for bonuses based on their performance but held harmless from penalties. Beginning in the second year, hospitals may be responsible for paying Medicare a portion of the episode spending based on their performance and whether they exceed

spending targets. Both CJR bonuses and penalties are capped and payment adjustments will be made retroactively following the close of the performance year.

**Cost evaluation:** Participant hospitals are evaluated based on the hospital's actual spending for the episode (total expenditures for related services under Medicare Parts A and B) and compared to the Medicare target episode price for a particular hospital. The episode target price is established based on expenditure data from previous years and is a blend of each participant's hospital-specific expenditure data and regional episode expenditure data. The episode target price will initially be based primarily on the participant hospital's own historical episode payments with a smaller portion of the target price coming from regional historical episode payments, but that balance shifts over time with target prices being based solely on regional data in program years four and five.

**Quality evaluation:** CMS will also tie each hospital's level of bonus or penalty to a composite quality score based on three measures: elective hip/knee arthroplasty complications within 90 days, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, and a voluntarily submitted patient-reported outcome measure. The composite quality score will take into account significant performance improvements in the complications and HCAHPS measures.

**Sharing savings with other providers:** Participant hospitals may enter into financial arrangements to share savings with "CJR collaborators" (which include skilled nursing facilities, long-term care hospitals, home health agencies, inpatient rehabilitation facilities, physician and non-physician practitioners, outpatient therapy providers and physician group practices), who are engaged in care redesign with the hospital and furnish services to Medicare beneficiaries during a beneficiary's CJR episode. CMS stipulates a number of conditions for the hospital to share savings with these CJR collaborators. Unfortunately, despite NAACOS' recommendations to exclude ACO beneficiaries from the demonstration unless a CJR hospital had an agreement with the ACO to partner in coordinating care, CMS did not include ACOs in the formal list of CJR collaborators. However, CMS explains that ACOs may enter into arrangements with a CJR hospital to coordinate the care of beneficiaries that are served by an ACO and have a CJR episode. CMS also states that in the event an ACO provides care coordination services to the hospital, the hospital is not precluded from compensating the ACO for the services.

**ACO financial implications:** Despite NAACOS' objections, CMS finalized a policy where the reconciliation of an ACO's financial performance will be adjusted for the results of the CJR patients, thereby removing an opportunity for the ACO to benefit financially from this demonstration and creating potential challenges to an ACO's ability to meet its own financial benchmarks for the high-quality care provided to all its Medicare beneficiaries. Ultimately, this carve-out chips away at an ACO's opportunity to earn shared savings from improving care and lowering costs through comprehensive population-based care.

**Fraud and abuse implications:** CMS and the HHS Office of Inspector General issued a separate joint statement waiving the anti-kickback, physician self-referral, and civil monetary penalty laws with respect to certain financial arrangements and beneficiary incentives under the CJR Model. There are also limited waivers for the skilled nursing facility three-day rule and for certain "incident to" billing rules, which would allow a CJR beneficiary to receive post-discharge visits in his or her home or place of residence during the episode. There are also waivers for geographic and originating site requirements that limit telehealth payments.

**Beneficiary impact:** Medicare beneficiaries included in the CJR Model still have full discretion to choose their providers or suppliers. CMS did not finalize their proposal to allow beneficiaries to decline having their data shared with participant hospitals, and CMS will provide these hospitals with as complete data on their beneficiaries as is possible under the law.