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.

NOTE: Subsequently, on December 20, 2016 CMS made revisions to CJR in its final Episode Payment rule. In this rule, CMS finalized an expansion of the CJR model to include additional surgical treatments for hip and femur fractures beyond hip replacement. CMS subsequently released an additional proposed rule cancelling the implementation of these models and making modifications to the original CJR model. More information is available on the CMS website.

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). As described above, CMS also expanded the CJR to also include additional surgical treatments for hip and femur fractures beyond hip replacement. The Surgical Hip/Femur Fracture Treatment (SHFFT) model anchor hospitalization would be defined by admission for a surgical procedure, which is defined by the MS-DRGs for that procedure as listed below. A SHFFT model episode would begin with the admission of a Medicare beneficiary to an IPPS

hospital for surgical treatment of hip or femur fracture (other than joint replacement) that is paid under the following SHFFT MS-DRGs and where the specific MS-DRG is called the anchor MS-DRG for the episode:

- 480 (Hip and femur procedures except major joint with major complication or comorbidity [MCC]))
- 481 (Hip and femur procedures except major joint with complication or comorbidity [CC])
- 482 (Hip and femur procedures except major joint without CC or MCC)

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. SHFT services will be included in the model beginning October 1, 2017.

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: CMS made adjustments to gainsharing requirements applicable to CJR in its final EPM rule. In this rule, CMS allows most ACOs to participate in both CJR and EPM models as "collaborators," which enables ACOs to participate in gainsharing arrangements under these models. This marks a shift in policy that will benefit ACOs, as the agency had previously proposed to exclude ACOs from the definition of CJR collaborators. Next Generation and Track 3 ACOs are excluded, as CMS excludes beneficiaries who are prospectively assigned to a Shared Savings Program ACO from CJR episodes. Collaborators are entities that CJR and EPM participants engage to make contributions to the participant's episode performance on spending or quality. The participant and collaborator share the reconciliation payments they may receive from CMS, the internal cost savings that the CJR or EPM obtains, and the financial responsibility for any repayments that are made to CMS. Aside from Next Generation and Track 3 ACOs, ACOs qualify to be both CJR collaborators and EPM collaborators.

Gainsharing payments, which are payments from an EPM or CJR participant to a collaborator, may be comprised only of EPM/CJR reconciliation payments, the EPM/CJR participant's internal cost savings, or some combination thereof. "Alignment payments," which flow from EPM/CJR collaborators back to EPM/CJR participants, may consist only of a portion of the amount owed by an EPM/CJR participant to CMS, called the "repayment amount."

In order to be eligible to receive a gainsharing payment or be required to make an alignment payment, an ACO must have contributed to EPM activities and been clinically involved in the care of EPM beneficiaries during the performance year for which the CJR participant-hospital accrued internal cost savings or earned the reconciliation payment that either comprises the gainsharing payment or was assessed a repayment amount. This means the ACO must have had an ACO provider/supplier that directly furnished an item or service rendered to an EPM beneficiary during an EPM episode in the appropriate performance year. Sharing arrangements, pursuant to which gainsharing and alignment payments are made, must be in writing, signed by the parties, and entered into before care is furnished under the relevant sharing arrangement. Additionally, participation in a sharing arrangement must be entirely voluntary, and no penalty may be applied for nonparticipation. Sharing arrangements must require collaborators to comply with program integrity requirements, including beneficiary notification requirements, access to records, record retention, and participation in any enforcement activities performed by CMS or its designees. The terms of a sharing arrangement cannot impair beneficiary access.

While an EPM/CJR participant may receive alignment payments from EPM/CJR collaborators, the amount of those payments cannot exceed 50 percent of the EPM/CJR participant's total repayment amount, and no individual EPM/CJR collaborator's alignment payments can account for more than 25 percent of the EPM/CJR participant's repayment amount. This is to ensure that EPM/CJR participants maintain an appropriate amount of responsibility for services they provide. However, recognizing the size and spending power of some ACOs, CMS allows alignment payments from ACOs to account for up to 50 percent of an EPM participant's repayment amount.

ACO financial implications: In the final EPM rule, CMS finalized a policy that will exclude beneficiaries aligned to MSSP Track 3 and Next Generation ACOs from EPMs including CJR. CMS will also exclude beneficiaries from EPMs who are aligned to End Stage Renal Disease (ESRD) Seamless Care Organizations (ESCOs) in the Comprehensive ESRD Care initiative in tracks with downside risk for financial losses. Shared savings payments to ACOs and losses repaid by ACOs to CMS have the potential to overlap with EPM reconciliation payments. CMS will attribute savings achieved during an EPM episode to the EPM participant, and it will include EPM reconciliation payments for ACO-assigned beneficiaries as ACO expenditures. NAACOS continues to oppose this approach. For EPMs CMS will make an adjustment to the reconciliation amount to account for any of the applicable discount for an episode resulting in Medicare savings that is paid back through shared savings under the MSSP or any other ACO model, but only when an EPM hospital also participates in the ACO and the beneficiary in the EPM episode is also assigned to that ACO. In these cases, CMS will reclaim from the EPM participant any discount percentage paid out as shared savings for ACOs when the hospital is an ACO participant and the beneficiary is aligned with that ACO. The agency explains that this adjustment is necessary to ensure that the applicable discount under the EPM is not reduced because a portion of that discount is paid out in shared savings to the ACO and thus, indirectly, back to the hospital. Recoupment takes place 14 months following the end of each performance period.

NAACOS has advocated for a blanket exclusion from EPMs for all ACO assigned patients. However, CMS justifies a more limited exclusion policy by stating that a blanket exclusion would dilute the volume of EPMs and thereby limit the agency's testing of these models. CMS also cites operational concerns with excluding ACO patients, who are not prospectively assigned. CMS therefore finalized this limited exclusion policy and states their intention to study the effects of the policy to improve their understanding of the appropriate

entity to hold accountable for the costs within the episode. CMS states that the agency may revisit this policy in future rulemaking.

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.

In the final EPM rule, CMS further clarified that Sharing arrangements under the EPM and CJR cannot be based on criteria including the volume or value of referrals, as the whole purpose of these sharing arrangements is to create financial alignment surrounding the shared goals of quality and efficiency in episodes of care. With this in mind, the criteria used to select EPM/CJR collaborators must include quality of care. When EPM/CJR participants enter into sharing arrangements with EPM/CJR collaborators such as ACOs, their compliance programs must include "oversight of sharing arrangements and compliance with the applicable requirements" of the EPM/CJR, which provides a "program integrity safeguard."
The calculation of gainsharing payments is subject to two requirements to protect against fraud and abuse. First, the methodology used to calculate gainsharing payments must be "transparent, measurable, and verifiable in accordance with generally accepted accounting principles (GAAP) and Government Auditing Standards (The Yellow Book)." Second, the methodology used to calculate savings must reflect the actual internal cost savings the EPM/CJR participant realizes through documentation of EPM/CJR activities and must exclude any other savings the entity might realize. Additionally, gainsharing payments shall not be made to collaborators subject to actions for noncompliance with the fraud and abuse laws.

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.