2020 CMS Proposed Rule Extending Comprehensive Care for Joint Replacement Model

Overview

The Comprehensive Care for Joint Replacement (CJR) model was implemented on April 1, 2016 and focuses on hip and knee replacements to test whether bundled payments for such episodes can improve the quality and reduce costs associated with these procedures. CMS recently released a proposed rule revising certain aspects of the CJR Model and extending the model for an additional three years through December 31, 2023, for those in mandatory regions. Proposed changes include altering episode of care definitions, target price calculations, the reconciliation process, beneficiary notice requirements, and the appeals process. The proposed rule also would remove the 50 percent cap on gainsharing payments for certain recipients in performance years six through eight. The rule also includes a solicitation of comments regarding how CMMI may design a future bundled payment model focused on lower extremity joint replacements (LEJR) performed in the Ambulatory Surgical Center (ASC) setting. This is a proposed rule and comments will be accepted through April 20, 2020. Comments may be submitted through the regulations.gov website here.

Key Provisions of the Proposed Rule

Extending the CJR Model

CMS proposes to extend the CJR model for an additional three years, through December 31, 2023, providing a performance year six through eight for participant hospitals located in the 34 mandatory metropolitan statistical areas (MSAs), excluding rural and low-volume hospitals. A list of mandatory MSAs for this model are available here.

Changes to Gainsharing Requirements

Currently, participant hospitals have been allowed to enter into sharing arrangements to make gainsharing payments to certain providers and suppliers with which they are collaboratively caring for CJR beneficiaries and to allow physician group practices to enter into distribution arrangements to share those gainsharing payments with certain PGP members. Currently, this includes allowing participant hospitals to enter into gainsharing arrangements, allow certain distribution payments and allow certain downstream distribution payments for ACOs, hospitals, CAHs, non-physician provider group practices (PPGPs) and therapy group practices (TGPs). After

monitoring the CJR participant hospitals and CJR claims data, CMS believes the burdens associated with the current caps on gainsharing payments outweigh the potential benefits of the payment limitations.

Specifically, CMS proposes to eliminate the 50 percent cap on gainsharing payments, distribution payments and downstream distribution payments when the recipient of these payments is a physician, non-physician practitioner, physician group practice (PGP) or non-physician practitioner group practice (NPPGP) for episodes that begin on or after January 1, 2021.

Changes to Definition of 'Episode of Care'

Due to changes in payment policy since the CJR model began, CMS is proposing to change the definition of a CJR episode. Specifically, these changes address alterations in the inpatient only (IPO) list, a set of procedure codes that CMS will only reimburse when performed in the inpatient setting, made in the 2018 and 2020 Outpatient Prospective Payment System (OPPS) rules. These changes include removing the Total Knee Arthroplasty (TKA) and Hip Arthroplasty (THA) procedure codes from the IPO list. Therefore, CMS proposes to change the definition of 'episode of care' for CJR to include outpatient procedures for TKAs and THAs.

CMS proposes to include permitted OP TKA/THA procedures in the definition of 'episode of care' in the CJR model beginning with performance year six, applicable to episodes initiated by an anchor procedure furnished on or after October 4, 2020. CMS also proposes to group the OP TKA procedures together with the MS-DRG 470 without hip fracture historical episodes in order to calculate a single, site-neutral target price for this category of episodes. Prices for the other three categories, MS-DRG 469 with hip fracture, MS-DRG 469 without hip fracture and MS-DRG 470 with hip fracture, would continue to be calculated based on historical inpatient episodes only.

Changes to Target Price Calculations

CMS proposes changes to the target price calculations for CJR. Specifically, CMS proposes changing the basis for the target price from three years to the most recent one year of claims data. CMS also proposes to remove the national update factor and remove updates to target prices that account for prospective payment system and fee schedule updates. CMS also proposes to remove anchor factors and weights and change the high episode spending cap calculation methodology.

Changes to Reconciliation Process

CMS also proposes to move from twice yearly reconciliations to one reconciliation that will take place six months after the close of each performance year. Additionally, CMS proposes to make other refinements to the reconciliation process including adding an additional episode-level risk adjustment beyond fracture status, change the high episode spending cap calculation methodology and add a retrospective market trend adjustment factor.

Changes to Quality Assessment

CMS also propose a quality change for CJR. CMS propose to adjust the quality discount factors applicable to participants with excellent and good quality scores to better recognize high quality care. Specifically, CMS proposes for performance years six through eight, a 1.5 percentage point reduction would be applied to the three percent discount factor for participant hospitals with composite quality scores greater than or equal to 6.9 and less than or equal to 15.0. Additionally, CMS proposes a three percentage point reduction be applied to the three percent discount factor for participant hospitals with composite quality scores greater than 15.0.
CMS is also proposing to increase thresholds for successful submission of Patient Reported Outcomes (PRO) measures as outlined in Table 5 (page 68) of the proposed rule, Proposed Potential Performance Period for Pre and Post Operative THA/TKA Voluntary Data Submission.

Changes to Beneficiary Notification and Payment Rule Waivers

CMS also proposes changes to beneficiary notification requirements for CJR, which are currently tied to admissions. CMS proposes that participant hospitals are required to notify the beneficiary of his or her inclusion in the CJR model if the procedure takes place in an outpatient setting.

CMS proposes to extend use of the Skilled Nursing Facility (SNF) 3-day rule waiver as well as the waiver of direct supervision requirements for certain post-discharge home visits to hospitals furnishing services to CJR beneficiaries in the outpatient setting.

Solicitation of Comments

CMS is soliciting comments on the design of a potential future bundled payment model for LEJR procedures in the Ambulatory Surgical Center (ASC) should CMS eventually cover LEJR procedures in the ASC setting.

These changes, if finalized, would not take effect until performance year six.